SERFF Tracking Number:	*TRST-128177448*	*State:*	*Arkansas*
Filing Company:	*Trustmark Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*12.00085*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.003A Small Group Only - PPO*
Product Name:	*S989C*		
Project Name/Number:	*Starmark 2011 Maintenance Filing/12.00085*		

Filing at a Glance

Company: Trustmark Life Insurance Company

Product Name: S989C	SERFF Tr Num: TRST-128177448	State: Arkansas
TOI: H16G Group Health - Major Medical	SERFF Status: Closed-Approved-Closed	State Tr Num:
Sub-TOI: H16G.003A Small Group Only - PPO	Co Tr Num: 12.00085	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Soula Vassilopoulos	Disposition Date: 05/01/2012
	Date Submitted: 04/25/2012	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Starmark 2011 Maintenance Filing	Status of Filing in Domicile: Authorized
Project Number: 12.00085	Date Approved in Domicile: 03/27/2012
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small
Group Market Type: Employer, Trust	Overall Rate Impact:
Filing Status Changed: 05/01/2012	
State Status Changed: 05/01/2012	Deemer Date:
Created By: Soula Vassilopoulos	Submitted By: Lisa Sayerstad

Corresponding Filing Tracking Number: 12.00085
PPACA: Non-Grandfathered Immed Mkt Reforms, Grandfathered Immed Mkt Reforms
PPACA Notes: null
Healthcare.gov ID:
Filing Description:
Please see filing letter under supporting documentation tab.
State Narrative:

Company and Contact

Filing Contact Information

SERFF Tracking Number:	*TRST-128177448*	*State:*	*Arkansas*
Filing Company:	*Trustmark Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*12.00085*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.003A Small Group Only - PPO*
Product Name:	*S989C*		
Project Name/Number:	*Starmark 2011 Maintenance Filing/12.00085*		

Soula Vassilopoulos, Compliance Analyst
400 Field Drive
Lake Forest, IL 60045

SV4@trustmarkins.com
847-283-2338 [Phone]
847-615-3872 [FAX]

Filing Company Information

Trustmark Life Insurance Company	CoCode: 62863	State of Domicile: Illinois
400 Field Drive	Group Code: 276	Company Type:
Lake Forest, IL 60045	Group Name:	State ID Number:
(800) 666-6977 ext. [Phone]	FEIN Number: 36-3421358	

Filing Fees

Fee Required?	Yes
Fee Amount:	$1,750.00
Retaliatory?	Yes
Fee Explanation:	AR filing fee is $50 per form. Domicile state (IL) fee is also $50 per form. 35 forms x $50 = $1,750.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Trustmark Life Insurance Company	$1,750.00	04/25/2012	58533480

SERFF Tracking Number:	*TRST-128177448*	*State:*	*Arkansas*
Filing Company:	*Trustmark Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*12.00085*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.003A Small Group Only - PPO*
Product Name:	*S989C*		
Project Name/Number:	*Starmark 2011 Maintenance Filing/12.00085*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/01/2012	05/01/2012

SERFF Tracking Number:	*TRST-128177448*	*State:*	*Arkansas*
Filing Company:	*Trustmark Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*12.00085*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.003A Small Group Only - PPO*
Product Name:	*S989C*		
Project Name/Number:	*Starmark 2011 Maintenance Filing/12.00085*		

Disposition

Disposition Date: 05/01/2012
Implementation Date:
Status: Approved-Closed
HHS Status: HHS Approved
State Review: Reviewed-No Actuary
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*TRST-128177448*	*State:*	*Arkansas*
Filing Company:	*Trustmark Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*12.00085*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.003A Small Group Only - PPO*
Product Name:	*S989C*		
Project Name/Number:	*Starmark 2011 Maintenance Filing/12.00085*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Cover/Filing Letter	Approved-Closed	Yes
Form	Title Page	Approved-Closed	Yes
Form	Schedule Pages (SS)	Approved-Closed	Yes
Form	Schedule Page (Gen)	Approved-Closed	Yes
Form	Definitions	Approved-Closed	Yes
Form	Definitions	Approved-Closed	Yes
Form	Comprehensive Medical Benefit Section	Approved-Closed	Yes
Form	Comprehensive Medical Benefit	Approved-Closed	Yes
Form	Comprehensive Medical Benefit	Approved-Closed	Yes
Form	Comprehensive Medical Benefit	Approved-Closed	Yes
Form	Covered Charges	Approved-Closed	Yes
Form	Covered Charges	Approved-Closed	Yes
Form	Covered Charges/Appl of Ded	Approved-Closed	Yes
Form	Covered Charges	Approved-Closed	Yes
Form	Covered Charges	Approved-Closed	Yes
Form	Exclusions	Approved-Closed	Yes
Form	Exclusions	Approved-Closed	Yes
Form	Exclusions	Approved-Closed	Yes
Form	Mammography	Approved-Closed	Yes
Form	Rx Drug for Cancer	Approved-Closed	Yes
Form	Pregnancy Infertility Rider	Approved-Closed	Yes
Form	Pre-certification	Approved-Closed	Yes
Form	Optional PPO Hospital	Approved-Closed	Yes
Form	PPO Plan	Approved-Closed	Yes
Form	Rx Drug Card	Approved-Closed	Yes
Form	RX Drug Card	Approved-Closed	Yes
Form	Rx Drug Exclsuion	Approved-Closed	Yes
Form	Transplant Benefit	Approved-Closed	Yes
Form	Transplant Benefit	Approved-Closed	Yes
Form	Conditions of Insurance	Approved-Closed	Yes
Form	Claim Payment Provisions	Approved-Closed	Yes
Form	Miscellaneous Provisions	Approved-Closed	Yes

SERFF Tracking Number:	*TRST-128177448*	*State:*	*Arkansas*
Filing Company:	*Trustmark Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*12.00085*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.003A Small Group Only - PPO*
Product Name:	*S989C*		
Project Name/Number:	*Starmark 2011 Maintenance Filing/12.00085*		

Form	Medicare	Approved-Closed	Yes
Form	Continuation	Approved-Closed	Yes
Form	Employee Enrollment Form	Approved-Closed	Yes
Form	Employer Application Form	Approved-Closed	Yes

SERFF Tracking Number:	*TRST-128177448*	*State:*	*Arkansas*
Filing Company:	*Trustmark Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*12.00085*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.003A Small Group Only - PPO*
Product Name:	*S989C*		
Project Name/Number:	*Starmark 2011 Maintenance Filing/12.00085*		

Form Schedule

Lead Form Number: S989C

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 05/01/2012	S989C	Certificate Amendment, Insert Page, Endorsement or Rider	Title Page	Initial			S989C.pdf
Approved-Closed 05/01/2012	S989C/SCH-04	Certificate Amendment, Insert Page, Endorsement or Rider	Schedule Pages (SS)	Initial			S989C SCH-04.pdf
Approved-Closed 05/01/2012	S989C/SCH(R1)	Certificate Amendment, Insert Page, Endorsement or Rider	Schedule Page (Gen)	Initial			S989C SCH(R1).pdf
Approved-Closed 05/01/2012	S989C/1-04(R3)	Certificate Amendment, Insert Page, Endorsement or Rider	Definitions	Initial			S989C 1-04(R3).pdf
Approved-Closed 05/01/2012	S989C/1.1-04	Certificate Amendment, Insert Page, Endorsement or Rider	Definitions	Initial			S989C 1.1-04.pdf
Approved-	S989C/13-	Certificate	Comprehensive	Initial			S989C 13-

Closed 05/01/2012	04(R5)	Amendment, Insert Page, Endorsement or Rider	Medical Benefit Section			04(R5).pdf
Approved-Closed 05/01/2012	S989C/13.1-04(R5)	Certificate Amendment, Insert Page, Endorsement or Rider	Comprehensive Medical Benefit	Initial		S989C 13.1-04(R5).pdf
Approved-Closed 05/01/2012	S989C/13.2-04(R2)	Certificate Amendment, Insert Page, Endorsement or Rider	Comprehensive Medical Benefit	Initial		S989C 13.2-04(R2).pdf
Approved-Closed 05/01/2012	S989C/13.3-04	Certificate Amendment, Insert Page, Endorsement or Rider	Comprehensive Medical Benefit	Initial		S989C 13.3-04.pdf
Approved-Closed 05/01/2012	S989C/14-04(R3)	Certificate Amendment, Insert Page, Endorsement or Rider	Covered Charges	Initial		S989C 14-04(R3).pdf
Approved-Closed 05/01/2012	S989C/15-04(R8)	Certificate Amendment, Insert Page, Endorsement or Rider	Covered Charges	Initial		S989C 15-04(R8).pdf
Approved-Closed 05/01/2012	S989C/15.1	Certificate Amendment, Insert	Covered Charges/Appl of Ded	Initial		S989C 15.1.pdf

		Page, Endorsement or Rider			
Approved-Closed 05/01/2012	S989C/16(R3)	Certificate Amendment, Insert Page, Endorsement or Rider	Covered Charges	Initial	S989C 16(R3).pdf
Approved-Closed 05/01/2012	S989C/16a-04(R1)	Certificate Amendment, Insert Page, Endorsement or Rider	Covered Charges	Initial	S989C 16a-04(R1).pdf
Approved-Closed 05/01/2012	S989C/16.1-04(R5)	Certificate Amendment, Insert Page, Endorsement or Rider	Exclusions	Initial	S989C 16.1-04(R5).pdf
Approved-Closed 05/01/2012	S989C/16.2-04	Certificate Amendment, Insert Page, Endorsement or Rider	Exclusions	Initial	S989C 16.2-04.pdf
Approved-Closed 05/01/2012	S989C/16.3-04	Certificate Amendment, Insert Page, Endorsement or Rider	Exclusions	Initial	S989C 16.3-04.pdf
Approved-Closed 05/01/2012	S989C/18(R4)	Certificate Amendment, Insert Page, Endorseme	Mammography	Initial	S989C 18(R4).pdf

		nt or Rider				
Approved-Closed 05/01/2012	S989C/23.1 (R2)	Certificate Amendment, Insert Page, Endorsement or Rider	Rx Drug for Cancer	Initial		S989C 23.1(R2).pdf
Approved-Closed 05/01/2012	S989C/25-04(R2)	Certificate Amendment, Insert Page, Endorsement or Rider	Pregnancy Infertility Rider	Initial		S989C 25-04(R2).pdf
Approved-Closed 05/01/2012	S989C/28(R4)	Certificate Amendment, Insert Page, Endorsement or Rider	Pre-certification	Initial		S989C 28(R4).pdf
Approved-Closed 05/01/2012	S989C/29(R4)	Certificate Amendment, Insert Page, Endorsement or Rider	Optional PPO Hospital	Initial		S989C 29(R4).pdf
Approved-Closed 05/01/2012	S989C/29-SN(R5)	Certificate Amendment, Insert Page, Endorsement or Rider	PPO Plan	Initial		S989C 29-SN(R5).pdf
Approved-Closed 05/01/2012	S989C/29.1 (R9)	Certificate Amendment, Insert Page, Endorsement or Rider	Rx Drug Card	Initial		S989C 29.1(R9).pdf
Approved-	S989C/29.2	Certificate	RX Drug Card	Initial		S989C

Closed 05/01/2012	(R9)	Amendment, Insert Page, Endorsement or Rider				29.2(R9).pdf
Approved-Closed 05/01/2012	S989C/29.2a(R6)	Certificate Amendment, Insert Page, Endorsement or Rider	Rx Drug Exclsuion	Initial		S989C 29.2a(R6).pdf
Approved-Closed 05/01/2012	S989C/29.3a(R2)	Certificate Amendment, Insert Page, Endorsement or Rider	Transplant Benefit	Initial		S989C 29.3a(R2).pdf
Approved-Closed 05/01/2012	S989C/29.3b(R2)	Certificate Amendment, Insert Page, Endorsement or Rider	Transplant Benefit	Initial		S989C 29.3b(R2).pdf
Approved-Closed 05/01/2012	S989C/36(R4)	Certificate Amendment, Insert Page, Endorsement or Rider	Conditions of Insurance	Initial		S989C 36(R4).pdf
Approved-Closed 05/01/2012	S989C/38(R4)	Certificate Amendment, Insert Page, Endorsement or Rider	Claim Payment Provisions	Initial		S989C 38(R4).pdf
Approved-Closed 05/01/2012	S989C/39(R2)	Certificate Amendment, Insert	Miscellaneous Provisions	Initial		S989C 39(R2).pdf

SERFF Tracking Number:	*TRST-128177448*		*State:*	*Arkansas*		
Filing Company:	*Trustmark Life Insurance Company*		*State Tracking Number:*			
Company Tracking Number:	*12.00085*					
TOI:	*H16G Group Health - Major Medical*		*Sub-TOI:*	*H16G.003A Small Group Only - PPO*		
Product Name:	*S989C*					
Project Name/Number:	*Starmark 2011 Maintenance Filing/12.00085*					
		Page, Endorsement or Rider				
Approved-Closed 05/01/2012	S989C/42(R4)	Certificate Amendment, Insert Page, Endorsement or Rider	Medicare	Initial		S989C 42(R4).pdf
Approved-Closed 05/01/2012	S989C/44.1(R3)	Certificate Amendment, Insert Page, Endorsement or Rider	Continuation	Initial		S989C 44.1(R3).pdf
Approved-Closed 05/01/2012	UW5 B AR (R2)	Application/Enrollment Form	Employee Enrollment Form	Initial		UW5 B AR (R2) (12-11) FINAL.pdf
Approved-Closed 05/01/2012	UW2 AR (R8)	Application/Enrollment Form	Employer Application Form	Initial		UW2 AR (R8) (09-11) FINAL.pdf

Certificate of Group Insurance Underwritten by **Trustmark Life Insurance Company**, Lake Forest, Illinois.

[SAMPLE]

Participating Employer:

[STARMARK
400 FIELD DRIVE
LAKE FOREST, IL 60045]

Group Number: [ZZ99999Z 0001]

Member ID: [123456789]

Class: [01]

Member Effective Date: [00/00/00]

The effective date of this certificate is: [00/00/00]

FURTHER INFORMATION REGARDING YOUR COVERAGE IS GIVEN ON THE PAGES WHICH FOLLOW. THIS CERTIFICATE IS EVIDENCE OF YOUR COVERAGE. IT IS NOT THE INSURANCE CONTRACT. ANY STATEMENT IN THIS CERTIFICATE WHICH CONFLICTS WITH THE CONTRACT IS VOID. THIS CERTIFICATE REPLACES ANY OTHER CERTIFICATE WHICH TRUSTMARK MAY HAVE ISSUED TO YOU.

YOUR COVERAGE IS INSURED BY TRUSTMARK LIFE INSURANCE COMPANY AND ADMINISTERED BY ITS AUTHORIZED REPRESENTATIVE, STAR MARKETING AND ADMINISTRATION (CALLED STARMARK IN THIS CERTIFICATE). ALL CLAIMS SHOULD BE SUBMITTED TO STARMARK AND ALL QUESTIONS REGARDING YOUR COVERAGE SHOULD BE DIRECTED TO STARMARK.

TRUSTMARK LIFE INSURANCE COMPANY

Joseph L. Pray
President & Chief Executive Officer

Dennis Schoff
Corporate Secretary & General Counsel

S989C

Certificate of Group Insurance Underwritten by **Trustmark Life Insurance Company**, Lake Forest, Illinois.

Schedule of Benefits
Comprehensive Medical Coverage

[Your coverage for this benefit is [**Member only.]]**

[Calendar Year][Plan Year] Deductible
[[$250] per person per [calendar Year][Plan Year]]
[[$750] per family per [calendar Year][Plan Year]]
Additional Emergency Room Access Fee
[$ 75] Emergency Room Access Fee (waived if admitted to the Hospital)
[[$ **35]** per Urgent Care Center visit]
[[$100] per Inpatient Hospital Confinement]
[[$100] per Day of Inpatient Hospitalization [(for the first [10] days of each hospitalization)]]
[[$100] per Outpatient surgery]
[[$100] per Non-surgical Outpatient Facility visit]
Pre-certification Requirement
[$300] penalty per Hospital stay or surgery (outside a physician's office) if the required Pre-certification procedures are not followed.

Note: There are no annual limits on the additional Deductible or Pre-certification Requirement penalty amounts and they will not count towards Your individual or family [calendar Year][Plan Year] Deductibles or Out-of-Pocket Limits.

<table>
<tr><td rowspan="2"></td><td colspan="2">[Insured Percent][Coinsurance]</td><td colspan="2">Out-of-Pocket Limit
[(includes [calendar Year][Plan Year] Deductible)]</td></tr>
<tr><td>In-Network</td><td>Out-of-Network</td><td>In-Network</td><td>Combined In-Network and Out-of-Network</td></tr>
<tr><td rowspan="2">Covered Charges other Than those listed below (after [calendar Year][Plan Year] Deductible)</td><td rowspan="2">[90%]</td><td rowspan="2">[70%]</td><td colspan="2">Individual
[$500] [$1,000]</td></tr>
<tr><td colspan="2" rowspan="2">Family
[$2,000]</td></tr>
<tr><td>Emergency Room Visit</td><td>[90%]</td><td>[90%]</td></tr>
<tr><td>Outpatient Mental Illness, Nervous Disorders, substance abuse and alcoholism (after [calendar Year][Plan Year] Deductible)</td><td>[90%]</td><td>[70%]</td><td colspan="2" rowspan="2">Charges not applied to Out-of-Pocket Limit</td></tr>
<tr><td>Inpatient Mental Illness, Nervous Disorders, substance abuse and alcoholism (after [calendar Year][Plan Year] Deductible)</td><td>[90%]</td><td>[70%]</td></tr>
<tr><td>[Office Visit Feature</td><td>[$15] [Encounter fee][Copay] [then 100% up to [$200] per visit[;]] then deductible/ coinsurance applies [maximum [12] visits per [calendar Year][Plan Year]]</td><td>[[70%] [$25] office visit deductible [then 100% up to [$200] per visit[;]] then deductible/ coinsurance applies [maximum [12] visits per [calendar Year][Plan Year]]</td><td colspan="2" rowspan="2">Not included in Out-of-Pocket Limit]</td></tr>
<tr><td>[Urgent Care Center Visit</td><td>[$20] Encounter fee [then 100% up to [$200] per visit][;] [maximum [12] visits per [calendar Year][Plan Year]]</td><td>[[70%] [$25] office visit deductible [then 100% up to [$200] per visit][;] [maximum [12] visits per [calendar Year][Plan Year]]]</td></tr>
</table>

[Specialty Office Visit]	[[$40] [Encounter fee][Copay] [then 100% up to [$200] per visit][;]] [maximum [12] visits per [Calendar Year][Plan Year]]	Not Available	

[Child immunization service - 100% for children from birth through age 18.]

[Optional benefits included]

[Pregnancy and Routine Nursery Care Coverage]

[Supplemental Accident Coverage – 100% up to [**$500**] per accident within [90] days of accident. Additional charges subject to [calendar Year][Plan Year] Deductible and [Insured Percent][Coinsurance]]
[Preferred Provider Plan]

[Prescription Drug Card Coverage:
[Applies to Preventive Prescription Drugs [only]]
[Applies after In-Network [calendar Year][Plan Year] Deductible is met. Prescription Drugs obtained at a Non-Member Pharmacy are subject to the Out-of-network [calendar Year][Plan Year] and Out-of-pocket amounts.]
[[$250] annual Prescription Deductible per person [for Preferred and Non-Preferred Drugs]
Copay per prescription: **[$10]** [or [30%] of the total drug cost] for Generic drugs[, whichever is greater]; **[$30]** [or [30%] of the total drug cost] for Preferred drugs[, whichever is greater]; **[$50]** [or [30%] of the total drug cost] for Non-Preferred drugs[, whichever is greater] [**[$200]** for Specialty Drugs] [or [30%] of the total drug cost] [, whichever is greater] [(up to a 30 Day Supply)];
[$20] [or [30%] of the total drug cost] for Generic Mail Order Drugs; **[$75]** [or [30%] of the total drug cost] for Preferred Mail Order Drugs; **[$150]** [or [30%] of the total drug cost] for Non-Preferred Mail Order Drugs; [**[$200]** for Specialty Drugs] [or [30%] of the total drug cost] [, whichever is greater] [(up to a 90 Day Supply)
[[[Annual] [Prescription Drug Out-of-Pocket Limit] [for Preferred and Non-Preferred Drugs (Does not include the Prescription Deductible)]]
[[[$2,500] [per person]]
[[$5,000] [per family]]]

[Prescription Drug Out-of-Pocket Limit] [for Preferred and Non-Preferred Drugs (Does not include the Prescription Deductible)]]
[[[$100] [per person per prescription]]

Note: The annual Prescription Deductible, Copay and Out-of-Pocket Limit amounts do not apply toward any other Deductible, Copay or Out-of-Pocket Limit described on this Schedule of Benefits.]

Preventive Care Services – 100% of In-Network preventive care procedures. Out-of-Network charges are subject to the Calendar Year Deductible and Coinsurance.

[Certificate of Group Insurance Underwritten by **Trustmark Life Insurance Company**, Lake Forest, Illinois.

Schedule of Benefits
Comprehensive Medical Coverage

Benefit maximums (per person)

Lifetime Dollar Maximum Amount
Essential Health Benefits.....Unlimited
[Non-Essential Health Benefits].....[$2,000,000]

[Autism Spectrum Disorders
Services related to Applied Behavior Analysis…….[$50,000] per calendar year]

[Physical therapy .....[[60] visits per [calendar Year][Plan Year].]]

[Occupational therapy.....[[60] visits per [calendar Year][Plan Year].]]

[Manipulative therapy.....[[10] visits per [calendar Year][Plan Year].]]

[Chronic Pain treatment programs.....[[10] visits per [calendar Year][Plan Year].]]

Hospice care.....[6] months per lifetime.

Skilled nursing care .....[81] days per [calendar Year][Plan Year].

Home health care .....[100] days per [calendar Year][Plan Year].

Drug Treatment related to Infertility……..[6] cycles per lifetime.

[Infertility / In Vitro Fertilization Services…….. $15,000 per lifetime.]

[Certificate of Group Insurance Underwritten by **Trustmark Life Insurance Company**, Lake Forest, Illinois.

Schedule of Benefits
Comprehensive Medical Coverage
Transplant Benefit

	[Insured Percent][Coinsurance]		
	Designated Transplant Facility	Non-Designated Transplant Facility In-Network	Non-Designated Transplant Facility Out-of-Network
Approved Transplant Services	[100%]	[100%]	[75%]
Transportation, Lodging and Meals of Companion	[100%]	[0%]	[0%]

Benefit maximums (per person)

Transportation of companion ..... [$1,000] per approved transplantation procedure

Lodging and meals of companion ..... [$250] per day while recipient of an approved transplant procedure is hospital confined
[[$10,000] per lifetime]

Approved Transplant Services done
at an Out-of-Network Non-Designated Transplant Facility…… [[$100,000] per lifetime][Unlimited]

Approved Transplant Services are those defined in the attached Certificate of Insurance. All charges for the Transplant Benefit are included in the lifetime maximum for this plan. See the first page of this Schedule of Benefits for maximum Out-of-Pocket limits.]

DEFINITIONS OF CERTAIN WORDS USED IN THIS CERTIFICATE

NOTE: All masculine pronouns used in this Certificate also include the feminine.

Applied Behavior Analysis: Means the design, implementation, and evaluation of environmental modifications by a board-certified behavior analyst using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Autism Spectrum Disorder: Means any of the pervasive developmental disorders as defined by the most recent edition of the "Diagnostic and Statistical Manual of Mental Disorders", including: autistic disorder; Asperger's disorder, and pervasive developmental disorder not otherwise specified.

Certificate: This booklet, including any attached riders, describing Your group insurance benefits.

Complications of Pregnancy: Means conditions which are not part of a normal pregnancy, but are caused by, or made worse by, pregnancy. They include, but are not limited to: (1) Caesarean section, ectopic pregnancy or similar puerperal infections, missed abortion, RH factor problems, severe loss of blood requiring transfusions; (4) acute nephritis, nephrosis, cardiac failure; (5) hyperemesis gravidarum; and (6) other similarly severe conditions related to pregnancy. Complications of pregnancy does not include; (1) false labor; (2) occasional spotting; (3) physician prescribed rest during pregnancy; (4) morning sickness; (5) pre-eclampsia; or (6) similar conditions which are part of a difficult pregnancy, but which are not a separate complication of pregnancy.

Contract: Means the contract issued to the Policyholder and any amendments, riders or endorsements to that contract.

Covered Person: An Employee[or Dependent] whose coverage under this Certificate is effective.

Dependent On Other Care Provider(s): Means the individual requires a community integrated living arrangement, group home, supervised apartment, or other residential services licensed or certified by the department of mental health and developmental disabilities, the department of public health, the department of public aid, or other appropriate state department responsible for such services or facilities.

[Domestic Partner: A person who completes the requisite affidavit of domestic partnership and who is of the same or opposite sex of the Employee who have chosen to share their lives in a close personal relationship in lieu of marriage with the Employee, and who:

(1) Share the same or regular and permanent residence, and have been living together as couple in the same household for at least 12 months;
(2) Have an exclusive mutual commitment in lieu of a lawful marriage;
(3) Have agreed to be jointly responsible for basic living expenses incurred during the domestic partnership;
(4) Are not married to anyone;
(5) Are each 18 years of age or older;
(6) Are not related by blood as close as would bar marriage;
(7) Are mentally competent to consent to a contract when the domestic partnership began;
(8) Are committed to the physical, emotional and financial care and support of each other and share with each other the common necessities and tasks of one household and are financially interdependent; and
(9) Are not involved in any other domestic partnership nor signed an affidavit of domestic partnership or its equivalent with a different Domestic Partner in any jurisdiction within 12 months immediately prior to the effective date of coverage.]

Eligible Dependent (Dependent): Includes: (1) Your legal spouse, [(2) Your Domestic Partner,] [(3)] Your child under [26 years] of age . **For any Dependent Life or Accidental Death and Dismemberment Benefits, the child is an Eligible Dependent only if he is over 14 days of age. For Comprehensive Medical and Dental Benefits only:** Your child who has coverage in force, who has reached the limiting age for children but who, because of a handicapped condition that occurred before attainment of the limiting age, is incapable of self-sustaining employment and is dependent upon You or Dependent On Other Care Provider (s) for lifetime care and supervision. Trustmark may request the Participating Employer to provide proof, at Trustmark's expense, of the child's incapacity or dependency. If the incapacity or dependency ends, the Participating Employer shall notify Trustmark.

NOTE: "Child as used above includes adopted children (including the time before the adoption is final [,and] and stepchildren, [and] [a child of a Domestic Partner]. But, Eligible Dependent will not include: a foster child; a child or spouse who lives outside of the USA; or spouse who is an Eligible Employee.

Eligible Employee: A person who is working for a Participating Employee for at least 30 hours per week has satisfied the waiting period, if any required, by the Participating Employer, and is a member of a class eligible for insurance.

Evidence-based Treatment: Means treatment subject to research that applies rigorous, systematic, and objective procedures to obtain valid knowledge relevant to Autism Spectrum Disorders.

Family Member: You, Your spouse, or the parent, child, brother or sister of You or Your spouse.

Gastric Pacemaker: Means a medical device that uses an external programmer and implanted electrical leads to the stomach; and transmits low-frequency, high-energy electrical stimulation to the stomach to entrain and pace the gastric slow waves to treat Gastroparesis.

Gastroparesis: Means a neuromuscular stomach disorder in which food empties from the stomach more slowly than normal.

Injury: Accidental bodily injury or injuries which cause a covered loss while a person's coverage is in force. the Injury must be the direct cause of the loss, independent of disease or bodily infirmity.

Insured: An Eligible Employee whose coverage has become effective.

Low Protein Modified Food Product: Means a food product that is specifically formulated to have less than one gram of protein per serving and intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease.

Medical Food: Means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a physician.

Medicare: Title XVIII of the Social Security Act of 1955, as amended. A person is considered to be eligible for Medicare on and after the date he is first eligible for any Medicare coverage.

Mental Illness or Nervous Disorders: Means neurosis, psychoneurosis, psychopathy, psychosis and mental disease or disorders as defined in the most current edition of the Diagnostic and Statistical Manual of Disorders of the American Psychiatric Association.

Participating Employer: An employer who has met the minimum participation requirements as described in the Policy and has been approved for coverage by Us. The Employer is named in the Schedule of Benefits.

Physician: A licensed medical doctor; surgeon; or any other licensed practitioner required to be recognized by state insurance law, acting within the scope of such license, who is not a Family Member.
Policyholder: The Starmark MET Group Insurance Trust.

Sickness: Illness, disease or Complications of Pregnancy which cause a covered loss while a person's coverage is in force; and for any Comprehensive Medical Benefits, congenital defects, birth abnormalities and prematurity of a covered newborn child.

Therapeutic Care: Means services provided by licensed speech therapists, occupational therapists, or physical therapists.

Trustmark Life Insurance Company: In this Certificate also called Trustmark, the Company, or We, Us or Our.

You and Your: The Insured named on the first page of this Certificate.

COMPREHENSIVE MEDICAL BENEFIT SECTION
([Calendar Year][Plan Year] Deductible)

This Benefit Applies Only If The Schedule Of Benefits Shows That You Have Comprehensive Medical Coverage.

We will provide benefits for medical expense incurred for the Medically Necessary care and treatment of Sickness or Injury. The amounts of coverage are shown in the Schedule of Benefits.

A. DEFINITIONS

Chronic Pain: Persistent and recurring pain that lasts longer than 6 months from the date the pain is first evaluated by a Physician.

[**Coinsurance:** The arrangement by which the cost of Covered Charges is shared by the Covered Person and Us on a percentage basis. The percentage paid by Us is shown on the Schedule of Benefits.]

Children's Preventive Health Care Services: The following services when provided in accordance with prevailing medical standards and delivered by, or supervised by, a Physician: a medical history; physical examination including routine tests and procedures to detect abnormalities or malfunctions of the body; developmental assessments; anticipatory guidance; and appropriate immunizations and laboratory tests.

Compound Medications: A randomly prepared dosage form. It must contain at least one Federal Legend Drug or State Restricted Drug within the compound.

Covered Charges: That part of expense incurred which: (a) is for care of a Covered Condition; (b) is incurred while a person's coverage is in force or as Extended Benefits; (c) does not exceed the Reasonable and Customary Fee; and (d) is either listed as a Covered Charge in Part B. of this Benefit, or is provided by and made part of this Benefit. Charges are considered incurred on the date a service is rendered or a supply is furnished.

Covered Condition: All Sickness and Injury for which a person is covered by this Benefit.

Creditable Coverage: Means coverage under any of the following:
1. a group health plan;
2. an individual health plan;
3. Part A and Part B of Medicare (Title XVIII of Social Security Act);
4. health plans for the uniformed services (Chapter 55 of Title 10, United States Code);
5. a medical care program of the Indian Health Service or of a tribal organization;
6. a state health benefits risk pool;
7. a health plan offered under Federal Employees Health Benefit Program (Chapter 89 of Title 5, United States Code);
8. a public health plan (as defined in regulations); or
9. a health benefit plan under Section 5(e) of the Peace Corps Act (U.S.C. 2504(e)).

Custodial Care: Means room and board and other institutional or nursing services which are provided for a Covered Person due to his age or mental or physical condition mainly to aid the person in daily living.

Deductible: The amount of Covered Charges that must be incurred by a person before benefits will be paid. The Deductible will be met when Covered Charges: (1) are incurred for Covered Conditions; and (2) are equal to the Deductible shown in the Schedule of Benefits.

Disability: You are Disabled if, due to Sickness or Injury, You are unable to do the substantial and material duties of Your regular job. A Dependent is Disabled if, due to Sickness or Injury, he is unable to do his normal activities.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition that places the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, a serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Emergency Services: With respect to an Emergency Medical Condition, a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required to Stabilize the patient.

Emergency Room Access Fee: The amount, in addition to the Plan Deductible, of Covered Charges that must be incurred by a person in the emergency room before benefits will be paid. The Emergency Room Access Fee will be met when Covered Charges: (1) are incurred for Covered Conditions; and (2) are equal to the Emergency Room Access Fee shown in the Schedule of Benefits. The Emergency Room Access Fee is waived if You are admitted to the Hospital.

Essential Health Benefits: Benefits for Medically Necessary care and treatment of Sickness or Injury. Essential Health Benefits does not include: Transportation, Lodging or Meals for a Companion under the Transplant Benefit.

Experimental/Investigational: A drug, device or medical treatment or procedure is "experimental" or "investigational":

1. if the drug or device cannot lawfully be marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished, or
2. if Reliable Evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
3. if Reliable Evidence shows that the consensus of opinion among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis.

"Reliable Evidence" means only published reports and articles in authoritative Medical and scientific literature; the written protocol or protocols used by the treating facility or the protocols of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

Federal Legend Drug: Any drug which must bear the following legend: ”Caution: Federal Law prohibits dispensing without a prescription.”

Free Standing Surgical Center: A facility licensed as a free standing or ambulatory surgical center.

Hospital: Includes all of the following:

1. An institution which: (a) is operated lawfully; and (b) mainly and continuously provides medical, diagnostic, and surgical facilities; these facilities may be on the premises or available on a prearranged basis supervised by a staff of one or more licensed Physicians; and (c) provides inpatient care for which a charge is made; and (d) provides 24-hour nursing care by, or supervised by, a registered graduate nurse (R.N.); or
2. An institution which is accredited as a Hospital by the Joint Commission on Accreditation of Health Care Organizations; or
3. Any other institution required to be recognized as a Hospital for benefit payment purposes under the law of the state in which You live.

"Hospital" does not include a nursing home or a custodial care facility.

[Imported Drugs: Prescription Drugs imported from outside the United States as permitted by regulations drafted in accordance with applicable federal law.]

[[**Insured Percent]:** The portion of Covered Charges We pay after the [calendar Year][Plan Year] Deductible.]

[[Insured Percent]: The portion of Covered Charges We pay after the [calendar Year][Plan Year] Deductible and depends upon whether You select a Preferred Provider (In-Network) or a Non-Preferred Provider (Out-of-Network). A list of Preferred Providers has been provided by Us.]

[Lab Vendor Program: The program through which You can receive laboratory services from the preferred laboratory service provider contracted by Us and indicated on Your laboratory ID card.]

Late Enrollee: A person who enrolls under a group health plan other than during the initial enrollment period. A person who is a Special Enrollee shall not be considered a Late Enrollee. [An 18 month postponement period will apply to all Late Enrollees.] However, an Eligible Employee or Dependent shall not be considered a Late Enrollee if:

1. The person:
   a. was covered under another employer health benefit plan at the time the person was eligible to enroll;
   b. has lost coverage under another Qualifying Previous Coverage as a result of termination of employment or eligibility, the involuntary termination of the Qualifying Previous Coverage, death of a spouse or divorce; and
   c. request enrollment within 30 days after the termination of the Qualifying Previous Coverage;
2. The person is employed by an employer that offers multiple health benefit plans and the person elects a different plan during an open enrollment period;
3. The person loses coverage under Medicaid or the Children’s Health Insurance Program (CHIP) or any successor program and requests enrollment within [60] days of the date coverage under Medicaid or CHIP, under Titles XIX and XXI of the Social Security Act, is ended as a result of loss of eligibility; or
4. A court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and the request for enrollment is made within 30 days after the issuance of the court order.

Lifetime Dollar Maximum: The maximum dollar amount of benefits We will pay on behalf of any Covered Person over the lifetime of that person shown in the Schedule of Benefits.

Medically Necessary: A service, drug, or supply that is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury in accordance with generally accepted standards of medical practice in the U.S. at the time the service, drug or supply is provided. When specifically applied to a confinement it further means that the diagnosis or treatment of the person's symptoms or condition cannot be safely provided to that person on an outpatient basis.

A service, drug, or supply shall not be considered as Medically Necessary if it:

1. is Experimental/Investigational, or for research purposes; or
2. is provided solely for the convenience of the patient, the patient's family, physician, hospital or any other provider; or
3. exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment; or
4. could have been omitted without adversely affecting the person's condition or the quality of medical care; or
5. involves the use of a medical device, drug, or substance not formally approved by the United States Food and Drug Administration; or
6. involves a service, supply or drug not approved for reimbursement by the Centers for Medicare and Medicaid Services or any successor organization; or
7. is a misrepresentation of services provided.

Benefit payment is subject to the determination by us that the service, drug or supply is Medically Necessary. The fact that a Physician may prescribe, authorize, or direct a service, drug or supply to be prescribed, does not of itself make it Medically Necessary or covered under this Certificate.

[**Out-of-Pocket Limit**: [The sum of the Deductible and]the percent of Covered Charges that You must pay each [calendar Year][Plan Year] for each Covered Person.] [The Out-of-Pocket Limit does not include the calendar Year Deductible.]]

Partial Confinement: Continuous treatment of mental illness, nervous disorders or substance abuse for at least 3 hours, but not more than 12 hours, in any 24-hour period. Treatment provided during Partial Confinement will be considered as treatment provided on a Hospital inpatient basis.

[Plan Year: The period from **[[**July**]** XX**]** of one Year through **[**June**]** XX**][** of the following Year**][**January 1st through December 31st of the same calendar Year**]**.]

Pre-existing Condition: A Sickness or Injury for which a person has during the 6 months just prior to his enrollment date under this plan, (1) received medical care, advice, or treatment; (2) had drugs or medicines prescribed whether taken or not; or had diagnostic tests ordered whether performed or not. Such condition will be deemed to be pre-existing whether or not a final diagnosis has been made. Pregnancy is not a Pre-existing Condition. Genetic information shall not be treated as a Pre-existing Condition in the absence of a diagnosis of the condition related to such information.

Prescription Drug(s): Drugs and medicines which are:
1. prescribed in writing by a Physician [in accordance with FDA-approved usage guidelines];
2. legally available only by a prescription;
3. dispensed through a licensed Pharmacy or Mail Order Service or administered in a Physician's office (not including sample(s)) or by inpatient Hospital and outpatient Hospital and non-Hospital providers and;
4. one of the following:
   a. Federal Legend Drugs;
   b. State Restricted Drugs; or
   c. Compound Medications.

Prescription Drugs include the following:
1. disposable insulin needles and syringes;][and]
2. disposable blood/urine glucose/acetone testing agents (Chemstrips, Acetest tablets, Clinitest tablets, Diastix Strips and Test-Tape); and
3. contraceptives, oral or other, whether medication or device, regardless of intended use[.][;]

[4. Specialty Drugs][;]
[5. Imported Drugs]

Qualifying Previous Coverage: Benefits or coverage provided under an employer-based health insurance or health benefit arrangement.

Reasonable and Customary Fee: [The fee payable by Us to [Non-Preferred] Providers. The Reasonable and Customary Fee, as determined by Us, is subject to applicable [Insured Percent][Coinsurance], Office Visit Deductible and Deductibles].

[1. For [Inpatient Hospital] [and] [Outpatient Hospital] and facilities, including but not limited to [Birthing Centers,] [Dialysis Facilities,] [Free-Standing Surgical Centers,] [Home Health Care,] [Hospice Care] [and] [Nursing Care Facilities,] the Reasonable and Customary Fee is the lesser of:
   a. The provider's actual charge; or
   [b. [100%-500%] of the average of the In-Network contracted rates, for the same service, of other similar providers in the same or similar geographic area in which the care is provided. To determine the geographic area, We use the methodology of an industrywide data system that collects data on providers' charges by zip code and procedure code.]
   [c. [100%-500%] of the Medicare reimbursement rate in effect at the time services were provided, as determined by an industrywide authoritative source.]
   [d. The cost to provide a particular service in a particular geographic area plus the average mark up in the particular area as determined by an industrywide authoritative source.]
   [e. The fee most often charged for the same service by providers in the same or similar geographic area in which the care is provided. To determine this amount, We use an industrywide data system that collects data on providers' charges. The industrywide data system arrays these charges and calculates percentiles. The Reasonable and Customary fee is the [40th-90th] percentile of these charges. This means that [40%-90%] of the charges are at or below the Reasonable and Customary Fee for the same service in the same or similar geographic area. The Reasonable and Customary Fee is developed from a statistically valid, timely sample, which equitably recognizes geographic variations. Unusual facts or problems which require more time, skill, and experience in connection with a service will also be considered in deciding benefits to be paid.]
   [f. The fee most often charged for the same service by providers in the same or similar geographic area in which the care is provided. To determine this amount, We use an industrywide data system that collects data on providers' charges by diagnosis-related-groups (DRGs). This methodology groups patients who are similar clinically and also in terms of the patients' consumption of resources. This methodology equitably recognizes geographic variations and unusual circumstances including the severity of the patient's condition.]]

[2. For [Outpatient Hospital] [and] [facilities,] [including, but not limited to, [Birthing Centers,][Dialysis Facilities,][Free-Standing Surgical Centers,][Home Health Care,] [Hospice Care,] [Nursing Care Facilities,] [and] [Urgent Care Facilities] the Reasonable and Customary Fee is the lesser of:
   a. The provider's actual charge; or
   [b. [100%-500%] of the average of the In-Network contracted rates, for the same service of other similar providers in the same or similar geographic area in which the care is provided. To determine the geographic area, We use the methodology of an industrywide data system that collects data on providers' charges by zip code and procedure code.]
   [c. [100%-500%] of the Medicare reimbursement rate in effect at the time services were provided, as determined by an industry-wide authoritative source.]
   [d. The cost to provide a particular service in a particular geographic area plus the average mark up in the particular area as determined by an industry-wide authoritative source.]
   [e. The fee most often charge for the same service by providers in the same or similar geographic area in which the care is provided. To determine this amount, We use an industry-wide data system that collects data on providers' charges. The industry-wide data system arrays these charges and calculates percentiles. The Reasonable and Customary fee is the [40th-90th] percentile of these charges. This means that [40%-90%] of the charges are at or below the Reasonable and Customary Fee for the same service in the same or similar geographic area. The Reasonable and Customary Fee is developed from a statistically valid, timely sample, which equitably recognizes geographic variations. Unusual facts or problems which require more time, skill, and experience in connection with a service will also be considered in deciding benefits to be paid.]]

3. For Physicians and Ambulance Services, the Reasonable and Customary Fee is the lesser of:
   a. The provider's actual charges; or
   [b. [100%-500%] of the average of the In-Network contracted rates, for the same service, of other similar providers In the same or similar geographic area in which the care is provided. To determine the geographic area, We use the methodology of an industrywide data system that collects data on providers' charges by zip code and procedure code.]
   [c. [100%-500%] of the Medicare Physician Fee Schedule payment amount; or]
   [d. The fee most often charged for the same service by providers in the same or similar geographic area in which the care is provided. To determine this amount, We use an industrywide data system that collects data on providers' charges and retains only the charge information by zip code and procedure code. The industrywide data system arrays these charges and calculates percentiles. The Reasonable and Customary fee is the [40th-90th] percentile of these charges. This means that [40%-90%] of the charges are at or below the Reasonable and Customary Fee for the same service in the same or similar geographic area. The Reasonable and Customary Fee is developed from a statistically valid sample which:
      i. equitably recognizes geographic variations;
      ii. is produced every six months; and
      iii. is collected on the basis of procedure codes developed and maintained by recognized authorities.
   Unusual facts or problems which require more time and skill in connection with a service will also be considered in deciding benefits to be paid.]]

[4. For prosthetic devices, orthotic devices, and Medical Equipment (Durable and Non-Durable), the Reasonable and Customary Fee is the lesser of:
   a. The provider's actual charge; or
   [b. [100%-500%] of the average of the In-Network contracted rates, for the same service or supply, of other similar providers [in the same or similar geographic area in which the care is provided. To determine the geographic area, We use the methodology of an industrywide data system that collects data on providers' charges by zip code and procedure code].]
   [c. The fee most often charged for the same service by providers [in the same or similar geographic area in which the care is provided]. To determine this amount, We use an industrywide data system that collects data on providers' charges by [zip code and] procedure code. The industrywide data system arrays these charges and calculates percentiles. The Reasonable and Customary fee is the [40th-90th] percentile of these charges.

This means that [40%-90%] of the charges are at or below the Reasonable and Customary Fee for the same service in the same or similar geographic area. The Reasonable and Customary Fee is developed from a statistically valid sample which:

i. equitably recognizes geographic variations;
ii. is produced every six months; and
iii. is collected on the basis of procedure codes developed and maintained by recognized authorities.

Unusual facts or problems which require more time and skill in connection with a service will also be considered in deciding benefits to be paid.]]

[5.] For Prescription Drugs or Specialty Drugs purchased without a Prescription Drug card, the Reasonable and Customary Fee:

a. is considered at [100%] of the average Wholesale Price determined by the manufacturer and published in, and updated [weekly] by, an industrywide data system that collects manufacturers' prices; and
b. [is exclusive of any drug manufacturer rebates.]

[Compound Medications will be considered at [100%] of the Average Wholesale Price [of the Compound's most expensive Federal Legend Drug or State Restricted Drug].]

[**Specialty Drug(s):** Certain Prescription Drugs are identified by Us as Specialty Drugs due to their cost, composition, storage requirements, and/or methods of administration. We maintain the list of Specialty Drugs on Our website; it is also available from the Customer Service phone number on your ID card. [If a Specialty Drug is also listed on a Formulary, it shall be covered as a Specialty Drug.]]

[**Specialty Provider**: Any Physician to whom a covered person has been referred for any specialized procedure. The Specialty Provider must be classified as a specialist by the American Board of Medical Specialties.]

Stabilize: No material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the Covered Person from a facility.

State Restricted Drug(s): Any drug which is legally available only by prescription under state law.

[**Urgent Care Center:** A facility, other than a Hospital, that provides services for Covered Conditions that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.]

[Year: The period from January 1st through December 31st of the same calendar Year.]

B. COVERED CHARGES

We will provide benefits for the following Covered Charges incurred after the Deductible has been met. Benefits will be paid at the [Insured Percent][Coinsurance] shown in the Schedule of Benefits.

Covered Charges:

1. Room, board and general nursing care for each day of confinement as an inpatient in a Hospital_including confinement solely for dental care or treatment, up to the most common semiprivate (two-bed) room rate at the Hospital where confined. However, only [95%] of a private (one-bed) room will be considered a Covered Charge in a Hospital with only private rooms.
2. Intensive care unit charges.
3. Miscellaneous services and supplies furnished by a Hospital on an inpatient basis and not included in the room charge. This benefit is paid only for expense incurred during a period for which the room and board or intensive care unit benefit is payable.
4. Miscellaneous services and supplies furnished by a Hospital or a Free Standing Surgical Center and related to outpatient surgery. This benefit is paid only for expense incurred on the date the surgery is performed.
5. Services and supplies furnished by a Hospital or a Free Standing Surgical Center for outpatient treatment of Injury.
6. Physician's fees. The following Physician's fees are limited as follows: (a) Benefits for treatment by manual or mechanical means of structural imbalance, distortion or subluxation in the vertebral column or elsewhere will be limited as shown in the Schedule of Benefits. Treatments that are [given under anesthesia or] considered maintenance in nature are not covered. (b) Benefits for treatment of Mental Illness or Nervous Disorders and substance abuse are limited as shown in the Schedule of Benefits. (c) Treatment for infertility is limited as shown in the Schedule of Benefits. No benefits are available for any other type of infertility treatment unless coverage is specifically added to this certificate. (d) Assistant surgeon expenses are limited to [20%] of the Reasonable and Customary Fee for the surgical procedure for which services are rendered.
7. Registered graduate nurse (R.N.) and licensed practical nurse (LPN) fees for private duty nursing care when recommended by a Physician. In-hospital private nursing services are covered only if the hospital's regular staff can't provide the care needed due to the nature of Your condition.
8. Local professional ambulance service to or from a Hospital. "Local" means the metropolitan area in which the person is located at the time service is used. If the person is in a rural area, "Local" means the nearest metropolitan area; transportation to and from the nearest Hospital with facilities for required special treatment including professional ambulance services and railroad or regularly scheduled airline fares. Ambulance service cannot be for Your convenience, Your Physician's or Your family's. It must be Medically Necessary.
9. Speech therapy for speech loss or impairment due to a Sickness or Injury.
10. The following Covered Charges when prescribed by a Physician and not included in 1. through 9. above:
    a. anesthetics and their administration;
    b. [exercise], physical and occupational therapist's fees. Benefits for [exercise], physical and occupational therapy are limited as shown in the Schedule of Benefits, however, treatments that are considered maintenance in nature are not covered;
    c. x-rays (but not dental x-rays) and laboratory tests done for diagnosis or treatment;
    d. x-ray, radium, cobalt and radioactive isotope therapy;
    e. blood and blood plasma;
    [f. chronic pain treatment. Benefits for chronic pain treatment are limited as shown in the Schedule of Benefits][;]
    g. Prosthetic devices, orthotic devices, and Durable Medical Equipment: The purchase of prosthetic devices, orthotic devices, and the rental of Durable Medical Equipment as Medically Necessary, including:
        i. Artificial limbs and eyes;
        ii. Crutches; canes; walkers; braces, devices which are custom-designed, fabricated, assembled, fitted or adjusted for the Covered Person, including necessary adjustments to shoes to accommodate braces (except that dental braces are not included);
        iii. Basic wheelchairs;
        iv. Basic hospital-type bed (except that repair, replacements and duplicates are not included);
        v. Oxygen and the rental of equipment for the administration of oxygen;
        vi. Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air conditioners, humidifiers, dehumidifiers, and other personal comfort items are not included).

        Prosthetic devices, orthotic devices, and Durable Medical Equipment must be provided by or under the direction of a Physician.

        Durable Medical Equipment may be purchased as determined by Us.
11. Prescription Drugs[

12. The following specific preventive care services:
    a. Physician office visits for routine physicals, limited to 1 visit per [calendar Year][Plan Year].
    b. C.B.C. (complete blood count).
    c. Chemistry panel.
    d. Hemocult.
    e. Urinalysis.
    f. Pap test
    g. Mammogram as provided elsewhere in the certificate.
    h. P.S.A. (prostate specific antigen) test for males age 40 and older.
    i. Immunizations (including flu and pneumonia shots).
    j Screening E.C.G. (electrocardiogram) for persons over age 40 who have 2 or more cardiac risk factors.

    [**Preventive Care Plus** - The same Covered Charges as the preventive care services listed above. Benefits are payable as shown in the Schedule of Benefits, and thereafter such services are subject to the Deductible and [Insured Percent][Coinsurance].][

12. Coverage for Preventive services will be paid in accordance with the following guidelines:
    a. U.S. Preventive Services Task Force
    b. Health Resources and Services Administration
    c. Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention

A complete list of Preventive services can be found at:
[www.healthcare.gov/center/regulations/prevention/recommendations.html]
In no event will benefits provided for Preventive services be less than that which is required by federal law.

Preventive services include, but are not limited to:

- Physician's Office Visit [(when the office visit is billed separate from the Preventive service, benefits will be considered "same as any other service" in accordance with the Schedule of Benefits)];
- Blood and other laboratory tests;
- Screening ECG (electrocardiogram) for persons over age 40 who have 2 or more cardiac factors;
- Immunizations;
- Pap test;
- Baseline mammogram between the ages of [35-39] and an annual mammogram at age [40] or older;[
- PSA (prostate-specific antigen) for males ages [40] or older;]
- Colorectal cancer screening;
- Counseling for tobacco use.

We may use reasonable medical management techniques to determine appropriate frequency, method or setting for a Preventive service to the extent such service is not specified in the guidelines or recommendations.]

13. Children's Preventive Health Care Service - 20 visits provided at approximately the following ages: Birth, 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 Years, 3 Years, 4 Years, 5 Years, 6 Years, 8 Years, 10 Years, 12 Years, 14 Years, 16 Years and 18 Years.
14. Tests done on a covered newborn for: hypothyroidism, phenylketonuria, galactosemia, tests for sickle-cell anemia, and all other disorders of the metabolism, as well as any testing of newborns mandated by law.
15. Medically necessary equipment, supplies and services for treatment of Type I, Type II and gestational diabetes when prescribed by a Physician, including diabetes self-management. Diabetes self-management training is limited to: (a) one per lifetime training program; and (b) an additional diabetes self-management training due to a significant change in symptoms or conditions. Diabetes self-management training must be provided in accordance with a program in compliance with the national Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.
16. Routine nursery care and pediatric charges for a covered newborn for up to 5 full days or until the mother is discharged from the Hospital following the birth of the child, whichever is earlier[.][;]
17. Care and treatment of loss or impairment of hearing.
18. Covered charges for a mastectomy, coverage includes:
    a. Reconstruction of the breast on which the mastectomy has been performed;
    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
    c. Prostheses and treatment for physical complications of all stages of mastectomy, including lymphedemas.[
19.][Colorectal cancer examinations and laboratory tests for colorectal cancer as prescribed by a Physician, in accordance with the published American Cancer Society guidelines.][
20.][Imported Drugs][
21.][Specialty Drugs][
22.][Covered charges incurred on an outpatient basis for laboratory services provided by the Lab Vendor Program are paid at [100%]. These charges are not subject to the [calendar Year][Plan Year] Deductible or [Insured Percent][Coinsurance]. Physician specimen collection fees are not considered covered charges under the Lab Vendor Program.][
23.][Covered Charges for each Physician's [or Urgent Care Center]office visit rendered by a Physician are subject to an office visit deductible. Office visit Covered Charges include charges for the visit, necessary x-rays and

laboratory tests, and non-surgical injections billed by the attending physician. This office visit deductible does not apply to preventive care services or any surgical procedure resulting from sickness or injury.][

24.] Covered Charges for Medically Necessary Medical Foods and Low Protein Modified Food Products for the treatment of phenylketornuria, galactosemia, organic acidemias, and disorders of amino acid metabolism, if the cost exceeds the Arkansas tax credit of $2,400 per individual, per year.[

25.] Covered Charges for Medically Necessary hospital or ambulatory surgical center facility charges and anesthesia charges for dental procedures provided to a Covered Person if the treating provider has certified that because of the patient's age, condition or problem, such hospitalization and general anesthesia is required to provide safe and effective treatment; and

a. a Dependent under seven (7) years of age if two (2) dentists licensed in the state have determined the Dependent requires, without delay, necessary treatment for a significantly complex dental condition; or
b. the Covered Person is a person diagnosed with a serious mental or physical condition; or
c. the Covered Person has a significant behavioral problem as determined by their physician.[

26.] Covered Charges for Medically Necessary services related to the diagnosis and treatment of Autism Spectrum Disorder; including, but not limited to:

a. Applied Behavior Analysis, for children under eighteen (18) years of age and when provided by or supervised by a board-certified behavior analyst;
b. pharmacy care;
c. psychiatric care;
d. psychological care;
e. Therapeutic Care; and
f. equipment determined necessary to provide Evidence-based Treatment[

27.] Covered Charges for Medically Necessary services related to Gastric Pacemakers to treat Gastroparesis.[

27.] Emergency Services.

[C. APPLICATION OF DEDUCTIBLE

The Deductible is shown in the Schedule of Benefits. The entire Deductible must be met before any benefits will be paid unless otherwise stated in this Certificate.]

[C. APPLICATION OF DEDUCTIBLE

1. The Deductible is shown in the Schedule of Benefits.
2. If two or more covered members of Your family are injured in the same accident, only one Deductible will be applied to all Covered Charges, combined for all covered persons, arising out of the accident during the Year.
3. A Deductible separate from the mother's must be met for a covered newborn child.
4. Covered Charges incurred by one person shall not be used to meet the Deductible for any other person. The only exceptions to this are set forth in 2. above and in the Schedule of Benefits.

[5. If a person incurs Covered Charges in the last 3 months of a Year which are used toward meeting the [calendar Year][Plan Year] Deductible, the amount of those charges will also be applied toward meeting his [calendar Year][Plan Year] Deductible for the next Year. Any Covered Charges incurred in the last 3 months of a Year which are used toward meeting the Out-of-Pocket Limit will not be used toward the Out-of-Pocket Limit for the next Plan Year.]]

[URGENT CARE CENTER VISIT DEDUCTIBLE
An additional deductible will apply to each Urgent Care Center visit [when such visit is not the result of an Emergency]. [The Urgent Care Center Visit Deductible is shown on the Schedule of Benefits and is separate from, and in addition to, the Deductible.]]

[INPATIENT HOSPITAL CONFINEMENT DEDUCTIBLE
An additional deductible will apply to each confinement in a PPO Hospital][or] [a[n] Out-of-Network] Hospital[when such confinement is not the result of an Emergency]. [The Inpatient Hospital Confinement Deductible is shown on the Schedule of Benefits and is separate from, and in addition to, the Deductible[and the Inpatient Hospital Per [Day] Deductible].]]

[INPATIENT HOSPITALIZATION PER DAY DEDUCTIBLE
An additional deductible will apply to each day in a PPO Hospital][or] a[n][In-Network PPO][or][Out-of-Network] Hospital[when such confinement is not the result of an Emergency]. The Inpatient Hospital Per Day Deductible is shown on the Schedule of Benefits and is separate from, and in addition to, the Deductible[and the Inpatient Hospital Per Confinement Deductible]].

The Individual Deductible applies separately to each Covered Person. [The Individual Deductible applies separately to a mother and newborn child.]]

[OUTPATIENT SURGERY DEDUCTIBLE
An additional deductible will apply to each surgical procedure performed in an outpatient facility [when such surgery is not the result of an Emergency]. [The Outpatient Surgery Deductible is shown on the Schedule of Benefits and is separate from, and in addition to, the Deductible.]]

[NON-SURGICAL OUTPATIENT FACILITY DEDUCTIBLE
An additional deductible will apply to each non-surgical outpatient facility visit [when such visit is not the result of an Emergency]. [The Non-surgical Outpatient Facility Deductible is shown on the Schedule of Benefits and is separate from, and in addition to, the Deductible.]]

D. MAXIMUM AMOUNTS

1. The Maximum Amount is shown in the Schedule of Benefits.

2. [The Out-of-Pocket Limit is the amount You must pay each [calendar Year][Plan Year] for each Covered Person. [The Out-of-Pocket Limit does not include any Deductible carried over from the last [3 months] of the prior [calendar Year][Plan Year], if applicable,] or any of the following amounts You which may be required to pay:
   [a. Copayments and office visit deductibles;]
   [b. Additional Deductibles or penalties;]
   [c. Prescription Deductibles or Prescription Copayments;][and]
   [d. Inpatient and outpatient charges for the treatment of Mental Illness and drug addiction, and outpatient treatment of alcoholism.]

   [When Covered Charges include both In-Network and Out-of-Network services, the maximum Out-of-Pocket Limit is the Out-of-Network Out-of-Pocket Limit.] When the maximum Out-of-Pocket Limit is reached, Covered Charges will be paid at [100%] until the end of the [calendar Year][Plan Year] or until the Plan Maximum is reached, whichever occurs first, except as otherwise noted.]

   [When Covered Charges include both In-Network and Out-of-Network services, separate maximum Out-of-Pocket Limits apply. When the maximum Out-of-Pocket Limit is reached, Covered Charges for similar services will be paid at [100%] until the end of the [calendar Year][Plan Year] or until the Lifetime Maximum Amount is reached, whichever occurs first, except as otherwise noted.]

[3. Your coverage includes an In-Network [Encounter Fee][Copay] and an Out-of-Network office visit deductible as shown on the Schedule of Benefits. Neither the [Encounter Fee][Copay] nor the office visit deductible apply toward the Deductible or Out-of-Pocket Limit. After the [Encounter Fee][Copay] or office visit deductible is paid, We will pay [100%] of the Covered Charges up to the maximum amount shown in the Schedule of Benefits. Additional Covered Charges are subject to the Deductible and [Insured Percent][Coinsurance].]

[3. Your coverage includes an In-Network [Encounter Fee][Copay] as shown on the Schedule of Benefits. The [Encounter Fee][Copay] does not apply toward the Deductible or Out-of-Pocket Limit. After the [Encounter Fee][Copay] is paid, We will pay [100%] of the Covered Charges up to the maximum amount shown in the Schedule of Benefits. Additional Covered Charges are subject to the Deductible and [Insured Percent][Coinsurance]. The [Encounter Fee][Copay] is shown in the Schedule of Benefits.]

[3. Your coverage includes an Out-of-Network office visit deductible as shown on the Schedule of Benefits. The office visit deductible does not apply toward the Deductible or Out-of-Pocket Limit. After the office visit deductible is paid, We will pay [100%] of the Covered Charges up to the maximum amount shown. Additional Covered Charges are subject to the Deductible and [Insured Percent][Coinsurance].]

E. EXTENDED BENEFITS

1. Benefits will be extended if a person is Disabled by a Covered Condition on any of the following dates:
   a. the date this Benefit terminates;
   b. the date the person is no longer in an Insurance Class eligible for this Benefit; or
   c. the date Your employer ceases to be a Participating Employer.
2. Extended benefits will be paid for a person as if his coverage were in force, but only for charges:
   a. due to the Injury or Sickness causing his Disability; and
   b. which would be payable if his coverage were in force.
3. Benefits will be extended for Covered Charges incurred before the earliest of the following:
   a. the end of a 12-month period that began on the date coverage ends if a Participating Employer terminates coverage for his employees under this Benefit; or
   b. the end of a 3-month period that began on the date coverage ends if an Eligible Employee loses coverage because he became disabled and the Participating Employer's coverage has not terminated;
   b. the date the Maximum Amount has been paid; or
   c. the date Disability ends or
   e. the date the person becomes eligible under any other group medical benefit or service plan.

   Benefits shall continue for any insured hospitalized on the date coverage terminates herein and is replaced by similar group coverage. Benefits shall continue until hospital confinement ends or benefits limits herein are reached, whichever is earlier.

F. BENEFIT LIMITATION FOR PRE-EXISTING CONDITIONS

For enrollees age 19 and older, no benefits will be paid for expenses that result from care or treatment of any Pre-existing Condition until the end of a 12-month period [, 18 months, in the case of a Late Enrollee,] during which the person with the Pre-existing Condition is continuously covered under this benefit.

The time a person was covered under Creditable Coverage will be credited against the limitation above if such Creditable Coverage was continuous and there was no break in coverage of more than 63 days before the effective date of this coverage, exclusive of any applicable waiting period.

G. EXCLUSIONS AND LIMITATIONS

1. The following exclusions and limitations will apply only to the extent permitted by the Patient Protections and Affordable Care Act of 2010 and corresponding regulations:
   - services or supplies not Medically Necessary, not performed or not required for the Covered Condition;
   - charges in excess of the Reasonable and Customary Fee for the services or supplies;
   - services or supplies not prescribed by a Physician as required to treat the Covered Condition;
   - dental care or treatment of any kind including [the removal of impacted wisdom teeth, except for bony impacted wisdom teeth, or] treatment of the gums and supporting structures and related medical care, services and supplies; this does not apply to damage to natural teeth caused solely by Injury (except chewing injuries) that occurs while a person is covered by this Benefit, and services are rendered while the patient is covered by this Benefit;
   - surgery of the jaw (orthognathic);
   - eyeglasses, contact lenses or hearing aids [, including cochlear implants,]and services or supplies related thereto;
   - eye examinations or orthoptic therapy; this does not apply to service or supplies required to correct Injury to the eyes that occurs while the person is covered by this Benefit;
   - Sensory Integration Therapy or Central Auditory Processing Disorder;
   - oral appliances for snoring or medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea;
   - hair prosthesis, hair transplants;
   - medical and surgical treatment of excessive sweating (hyperhidrosis);
   - cosmetic surgery; including surgery of the eyelid (Blepharoplasty); this does not apply to Covered Charges for: (a) correction of damage caused by Injury or Sickness; or (b) congenital deformities of a newborn child covered by this Benefit from the date of birth;
   - routine physical examinations, x-rays, lab tests or other diagnostic tests, except as specified elsewhere in this certificate or an additional Benefit to this certificate.
   - loss due to war, or act of war, declared or undeclared;
   - loss due to the person's participation in a riot;
   - loss which occurs during or as a result of Your participation in the commission of, or attempt to commit a felony;
   - services, supplies, care or treatment given to a Covered Person for an Injury or Sickness which occurred as the result of that Covered Person being intoxicated or under the influence of alcohol;
   - services, supplies, care or treatment given to a Covered Person for an Injury or Sickness which occurred as the result of or was contributed to by that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of, and in accordance with the direction of a Physician. Covered Charges will be paid for injured Covered Persons who were other than the person under the influence of the controlled substance, drug, hallucinogen or narcotic;
   - services, supplies, care or treatment for an Injury or Sickness which occurred as the result of that Covered Person taking of any over the counter medication unless taken as directed;
   - loss to which a contributing cause was the person engaging in an illegal occupation;
   - charges the person is not legally required to pay[, including charges in the absence of insurance for services or supplies provided,] [or paid for by, any federal, state or local government (except under Medicaid)] or [services previously billed as part of a related service and not considered reasonable and necessary by the Centers for Medicare and Medicaid Services or any successor organization];
   - charges for missed or canceled appointments, [stand-by charges or after hours,] surcharges for weekend office visits that are not an Emergency, or home visits by a Physician;
   - services or supplies furnished by a person who usually resides in Your home or who is a Family Member
   - items for comfort or convenience, including but not limited to television, telephone, beauty/barber services, guest services, and supplies, equipment or similar incidental services and supplies for personal comfort, such as air conditioners, air purifiers and filters, batteries, battery chargers, dehumidifiers, and humidifiers;
   - expenses incurred as part of a rest cure, or at a health spa or similar facility;
   - loss due to suicide, or attempted suicide, if the suicide/attempted suicide is not the result of a medical condition;
   - loss due to intentionally self-inflicted injury, if the Injury is not the result of a medical condition;

- treatment of abnormal breast enlargement in males (benign gynecomastia);
- sex transformation surgery and related drugs and services, or the reversal thereof;
- drugs, therapies and treatment for the restoration or enhancement of sexual activity [for any person age 18 or less];
- immunizations, x-rays or tests not related to diagnosis or treatment of Sickness or Injury;
- Experimental/Investigational drugs, medicines, treatment, procedures and therapies;
- services and supplies related to alternative or complementary medicine, including but not limited to [acupressure,] [acupuncture,] [aroma therapy,] [bioenergial synchronization technique (BEST),] [biofeedback,] [contact reflex analysis,] [holistic medicine,] [herbal therapy,] [hypnotism,] [iridology (study of the iris),] [massage therapy,] [naturopathy,] [reike therapy,] [rolfing,] [thermograph,] or other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health or any similar or successor organization;
- application of medications through the skin with the use of high frequency sound waves (phonophoresis)
- surface electromyogram (EMG);
- charges for [family or marriage counseling,] [aversion therapy,] [non-medical self care or self help programs];
- nutritional counseling for [chronic fatigue] [and] [Attention Deficit Disorder Hyperactivity Disorder (ADD/HDD)];
- treatment for weight reduction, [for medical and non-medical reasons, including but not limited to: weight reduction or weight control surgical procedures, devices, regimens, treatments, therapies, services or products; [also including anorectics or any drugs used for weight control; nutrition-based therapy and counseling];
- dietary supplements, vitamins, and mega-vitamins, except for prenatal vitamins and vitamin B12 injections;
- Cryoanalgesia and therapeutic cold devices;
- any drug containing nicotine for the purpose of use as a smoking deterrent or other smoking deterrent medications;
- treatment (including cutting or removal) of toe nails or superficial lesions of the feet including corns, calluses and hyperkeratoses, other than removal of nail matrix or root;
- hygienic and preventive maintenance foot care, treatment of flat feet, subluxation of the foot, or shoe orthotics, except as shown in Covered Charges;
- gait analysis;
- work hardening programs – (a series of conditioning exercises performed in a rehabilitation program designed to simulate functional tasks on the job to which an individual will return);
- maintenance occupational therapy and maintenance physical therapy; behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap, or mental retardation;
- Custodial Care[;]
- surrogate parenting;
- reversal of sterilization;
- [any Sickness or Injury which occurs while working for wage or profit. This exclusion will not apply to a Participating Employer who: (a) is a sole proprietor, partner or executive officer; and (b) is not required by law to have Workers Compensation or similar coverage; and (c) does not have such coverage][;]
- [artificial insemination, in-vitro fertilization, and any other form of assisted conception except as specified elsewhere in this certificate or by a specific benefit added to this certificate][;]
- [elective abortions][;]
- [normal pregnancy or routine obstetrical care][;]
- [routine nursery care or well baby care][;]
- [prescription antihistamines][;]
- [non-prescription drugs][;]
- [Imported Drugs[;]]
- [Specialty Drugs]
- [birth control pills, drugs or devices][;]
- [home traction devices][;]
- [services or supplies furnished by the Participating Employer, by any employee of the Participating Employer, or by any person who is in partnership with, or other formal business relationship with the Insured or the Participating Employer.]

2. No benefits will be paid under this Benefit, or under any Benefit r made part of it for, services or supplies that a person received before his effective date of coverage under this Benefit.
3. No benefit will be paid under this Benefit, or under any Benefit made part of it for, services or supplies that a person received after the date his coverage terminated under this Benefit, except as specified under the Extended Benefits provisions.
4. Benefits will be limited as follows.
   a. Dental procedures to correct TMJ are not covered.
   b. Benefits for prosthetic or orthotic devices are limited to once every three (3) years unless medically necessary, or required due to progression of a Sickness or Injury or growth of a child.
   c. Benefits for Mental Illness, Nervous Disorders, substance abuse, and alcoholism are limited as shown in the Schedule of Benefits.
5. No benefits are payable for any medical treatment other than treatment for emergencies outside the United States.

[**MAMMOGRAPHY SCREENING BENEFIT**

This Benefit Applies Only If The Schedule Of Benefits Shows That You Have Comprehensive Medical Coverage.

A. DEFINITION

Low-Dose Mammography: Means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device and image receptor, with radiation exposure delivery of less than one rad per breast for two views of an average size breast.

B. BENEFITS

Benefits will be paid for Covered Charges incurred for screening by Low-Dose Mammography by a covered person age 35 or older while coverage is in force. Benefits will be paid as follows.

1. A baseline mammogram for each such person 35 to 39 Years of age.

2. An annual mammogram for each such person 40 Years of age or older.

a. A Medically Necessary mammogram, as determined by a person's health care provider, for each such person who has a family history of cancer or other risk factors.

Benefits will be paid at the [Insured Percent][Coinsurance] of the Comprehensive Medical Benefit, as shown in the Schedule of Benefits, after the Deductible has been met.

[Benefits may be subject to a separate [Encounter Fee][Copay] whether performed at a Physician's office visit or at a different location and time from the office visit, if the [Encounter Fee][Copay] is shown in the Schedule of Benefits.]]

PRESCRIPTION DRUGS FOR CANCER TREATMENT BENEFIT

This Benefit Applies Only If The Schedule Of Benefits Shows That You Have Comprehensive Medical Coverage.

A. DEFINITION

Prescription Drugs for Cancer Treatment: Drugs prescribed by a physician, whether or not they have been approved by the U.S. Food and Drug Administration (FDA) for the treatment of the specific type of cancer for which the drug has been prescribed. The drug, however, must be approved by the FDA and it must also be recognized for treatment of that specific type of cancer in any one of the following:

1. the American Medical Association Drug Evaluation;
2. the American Hospital Formulary Service Drug Information; or
3. the United States Pharmacopedia Drug Information.

If not listed in any of the above compendia, the drug must be recommended for that specific type of cancer in formal clinical studies. The results of the clinical studies must have been published in at least two peer reviewed professional medical journals published in the United States or Great Britain.

B. BENEFITS

Benefits will be paid for Covered Charges incurred by You or Your Dependent for prescription drugs used for the treatment of cancer.

C. EXCLUSION

No benefits will be paid for Experimental/Investigational cancer drugs of any cancer drug that the FDA has determined to be contraindicated for treatment of the specific type of cancer for which the drug was prescribed.

[PREGNANCY, INFERTILITY, AND ROUTINE NURSERY CARE BENEFIT

This Benefit Applies Only If The Schedule of Benefits Shows That You Have Pregnancy and Routine Nursery Care Coverage.

A. DEFINITIONS

Pregnancy: The condition of a female from the time of conception until the birth of the baby.

[Elective Abortion: Abortion other than:
1. abortion performed when the person's life or health would be endangered if the abortion was not done;
2. abortion performed when the Pregnancy results from rape or incest; or
3. spontaneous abortion.]

Routine Nursery Care: Means room, board and general nursing care provided while a covered well newborn child is confined in a Hospital following birth.

B. BENEFITS

PREGNANCY & ROUTINE NURSERY

Regardless of any exclusions in the Comprehensive Medical Benefit section to the contrary, benefits will be paid for Covered Charges incurred for Pregnancy or Elective Abortion by You or Your Dependent while coverage is in force.

Covered Charges include:
a. Pre-natal and post-natal care and delivery;
b. Routine Nursery Care;
c. Physician fees for the first visit to examine a newborn in the Hospital following birth;
d. Physician fees for circumcision of a newborn; and
e. Elective Abortion services.

Covered Charges will include a minimum of [48 hours] in the Hospital following a vaginal delivery or [96 hours] following a cesarean, unless You and Your Physician agree on an earlier discharge. In the event of any early discharge, You will be entitled to [one follow-up visit] within [48 hours] of discharge from the Hospital. You may choose to have this visit take place at Your home or Your Physician's office. During the visit, services may include, but are not limited to, physical assessment of the newborn, parent education, assistance training in breast or bottle feeding, assessment of the home support system, and the performance of any Medically Necessary and appropriate clinical tests consistent with protocols and guidelines developed by national pediatric, obstetric and nursing professional organizations for such services.

INFERTILITY
Benefits will be paid for expenses of an insured or the covered spouse for infertility procedures if:

1. The insured's oocytes are fertilized with the insured's spouse's sperm;
2. The insured and his spouse have a history of unexplained infertility of a least 2 years or infertility is associated with one or more of the following medical conditions;
   a. Endometriosis;
   b. Exposure in utero to diethylstilbestrol (DES);
   c. Blockage of, or surgical removal of, on or both fallopian tubes (lateral or bilateral salpingectomy); or
   d. Abnormal male factors contributing to the infertility;
3. The insured has been unable to attain a successful pregnancy through any less costly applicable infertility treatment covered herein; and
4. Procedures are performed at a facility that is licensed or certified by the Arkansas Dept. of Health and; (a) is a medical facility; (b) conforms to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics; or (c) meets the American Fertility Society minimal standards for programs of in vitro fertilization.

Covered Charges include:
   a. In vitro fertilization;
   b. Cyropreservation; and
   c. All other medically appropriate infertility services or treatments..

Benefits for all services and treatments relating to infertility, including in vitro fertilization, will be paid up to the maximum shown in the Schedule of Benefits.]

How to Pre-certify: You or the attending Physician must call the telephone number for Pre-certification shown on Your identification card. The call must be made prior to the service being rendered.

In the case of an Emergency Admission, the call should be made within 48 hours after care has begun, or by the next regular working day. If it is not reasonably possible to make the call within the times provided, payment will not be reduced if the call is made as soon as reasonably possible.

Be prepared to give the following information:
1. Your name, social security number, and the group plan number;
2. patient's name and date of birth;
3. the name and address (if applicable) of the healthcare facility, Home Health Care agency or hospice;
4. Physician's name and telephone number;
5. the diagnosis (what is wrong); and
6. the treatment (what will be done and when)

It is Your responsibility to ensure that proper Certification is made. We recommend that You follow-up with the attending Physician to ensure that all medical information is provided. Confirmation of the Certified treatment will be provided to You, the attending Physician, and the health care facility (if applicable). If We do not agree that the treatment is Medically Necessary according to the terms of this Contract, You will be informed in writing. You or Your Physician may, at any time, request a reevaluation of the treatment being Certified.

Certification will be valid for [60] days for the requesting Physician and the named health care facility. A change in either will require a new Certification.

OPTIONAL PREFERRED HOSPITAL BENEFIT

This Benefit Applies Only If The Schedule Of Benefits Shows That You Have A Preferred Provider Plan.

A. DEFINITIONS

Preferred Hospital: Means a Hospital that has contracted with Us , through a preferred provider network, to be reimbursed at discounted fees.

Non-Preferred Hospital: Means any other Hospital.

Emergency: Means an Injury or the sudden onset of a medical condition. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care the person could reasonably expect that: (a) his life or health would be in serious jeopardy; (b) his bodily functions would be seriously impaired; or (c) a body organ or part would be seriously damaged. Your Physician must contact the preferred provider network within 48 hours after an Emergency Hospital admission or by the next business day, if later, or as soon as reasonably possible. He must give: (1) the reason for the admission; and (2) the details of the treatment received.

B. BENEFITS

We encourage all Covered Persons to use Preferred Hospitals by providing benefit incentives when Preferred Hospitals are used. By using a Preferred Hospital, You make optimum use of Your plan.

1. In the event that a Preferred Hospital is used, You make maximum use of Your benefits as shown in the Schedule of Benefits.

2. In the event that a Non-Preferred Hospital is used, benefits will be reduced as shown in the Schedule of Benefits.

3. In the event of an Emergency, services rendered by any Hospital (Preferred or Non-Preferred) due to and within the first 24 hours after the onset of the Emergency are covered as if the service had been provided by a Preferred Hospital. After the first 24 hours, services rendered by a Non-Preferred Hospital to treat the Emergency will continue to be covered as if rendered by a Preferred Hospital only until the person can reasonably and safely be transferred so as to receive services by a Preferred Hospital.

[PREFERRED PROVIDER PLAN

This Benefit Applies Only If The Schedule Of Benefits Shows That You Have A Preferred Provider Plan.

A. DEFINITIONS

[Encounter Fee][Copay]: The amount of each Physician[or] [Specialty Provider][Urgent Care Center] visit charge that the person must pay. This amount does not apply toward satisfaction of any deductible or the coinsurance out-of-pocket maximum. The [Encounter Fee][Copay] is shown on the Schedule of Benefits.

Non-Preferred Provider: All providers of health care services that are not Preferred Providers. When Non-Preferred Providers are used, benefits will be paid at the out-of-network level shown on the Schedule of Benefits.

Preferred Provider: A Hospital, Physician or others that are contracted with a Preferred Provider Network that has an arrangement with Us to render health care services to Covered Person. When Preferred Providers are used, benefits will be payable at the in-network level shown on the Schedule of Benefits. Otherwise, benefits will be payable at the out-of-network level. The Preferred Provider Network is shown on Your medical ID card. [A Preferred Provider does [not] include a Pharmacy.] [Your plan may include a specialty network of mental health care providers. For Covered Charges for mental health treatment to be considered in-network, You must contact the specialty network shown on Your medical ID card.]

B. BENEFITS

(1) Preferred Hospitals

Covered Persons are encouraged to use Preferred Hospitals with benefit incentives. By using a Preferred Hospital, You make optimum use of Your plan.

a. In the event that a Preferred Hospital is used, You make maximum use of Your benefits as shown in the Schedule of Benefits.

b. In the event that a Non-Preferred Hospital is used, benefits will be reduced as shown in the Schedule of Benefits.

c. In the event of an Emergency, services rendered by any Hospital (Preferred or Non-Preferred) due to and within the first 24 hours after the onset of the Emergency are covered as if the service had been provided by a Preferred Hospital. After the first 24 hours, services rendered by a Non-Preferred Hospital to treat the Emergency will continue to be covered as if rendered by a Preferred Hospital only until the person can reasonably and safely be transferred so as to receive services by a Preferred Hospital.

(2) Preferred Provider

[[Covered Persons are encouraged to use Preferred Providers with benefit incentives. Covered Charges for each office visit rendered by a Preferred Provider [or Specialty Provider] [, including a physician office visit for one routine physical per Year,] are subject to an [Encounter Fee][Copay]. Office visit Covered Charges include charges for the visit, necessary x-rays and non-surgical injections billed by the attending physician. The office visit feature does not apply to laboratory tests or any surgical procedure resulting from sickness or injury. For each visit to a Preferred Provider, a person will only need to pay the [Encounter Fee][Copay]. Preferred Provider charges for services other than an office visit are subject to the in-network Deductible and [Insured Percent][Coinsurance] as shown on the Schedule of Benefits. Charges for services provided by Non-Preferred Providers are subject to the out-of-network Deductible and [Insured Percent][Coinsurance] as shown on the Schedule of Benefits.]]

[Benefits payable for out-of-network [Radiologists,] [Anesthesiologists,] [Pathologists], [hospital based Physicians,][and][assistant surgeons,] will be paid at the in-network level, subject to the Reasonable and Customary Fee, as long as the services provided are covered services ordered by a Preferred Provider or are covered services provided during a covered Preferred Provider facility stay or visit.]

[[Covered Persons are encouraged to use Preferred Providers with benefit incentives. Covered Charges for each office visit rendered by a Preferred Provider [or Specialty Provider] are subject to an [Encounter Fee][Copay]. Covered Charges for each office visit by a Non-Preferred Provider are subject to an office visit deductible. Office visit Covered Charges include charges for the visit, necessary x-rays [and laboratory tests,] and non-surgical injections billed by the attending physician. The office visit feature does not apply to preventive care procedures or any Surgical Procedure resulting from sickness or injury. Preferred Provider charges for services other than an office visit are subject to the in-network Deductible and [Insured Percent][Coinsurance] as shown on the Schedule of Benefits. Charges for services provided by Non-Preferred Providers are subject to the out-of-network Deductible and [Insured Percent][Coinsurance] as shown on the Schedule of Benefits.]]

[Benefits payable for out-of-network [Radiologists,] [Anesthesiologists,] [Pathologists,], [hospital based Physicians,][and][assistant surgeons,] will be paid at the in-network level, subject to the Reasonable and Customary Fee, as long as the services provided are covered services ordered by a Preferred Provider or are covered services provided during a covered Preferred Provider facility stay or visit.]

[[Covered Persons are encouraged to use Preferred Providers with benefit incentives. Covered Charges for each office visit rendered by a Preferred Provider [or Specialty Provider] are subject to an [Encounter Fee][Copay]. Office visit Covered Charges include charges for the visit, necessary x-rays [and laboratory tests,]and non-surgical injections billed by the attending physician. The office visit feature does not apply to preventive care procedures or any surgical procedure resulting from sickness or injury. Preferred Provider charges for services other than an office visit are subject to the in-network Deductible and [Insured Percent][Coinsurance] as shown on the Schedule of Benefits. Charges for services provided by Non-Preferred Providers are subject to the out-of-network Deductible and [Insured Percent][Coinsurance] as shown on the Schedule of Benefits.]

[Benefits payable for out-of-network [Radiologists,] [Anesthesiologists,] [Pathologists,], [hospital based Physicians,][and] [assistant surgeons,] will be paid at the in-network level, subject to the Reasonable and Customary Fee, as long as the services provided are covered services ordered by a Preferred Provider or are covered services provided during a covered Preferred Provider facility stay or visit.]

[[Covered Persons are encouraged to use Preferred Provider with benefit incentives. Preferred Provider [or Specialty Provider] charges are subject to the in-network Deductible and [Insured Percent][Coinsurance] as shown on the Schedule of Benefits. Non-Preferred Provider charges are subject to the out-of-network Deductible and [Insured Percent][Coinsurance] as shown on the Schedule of Benefits. [Benefits payable for out-of-network Radiologists, Anesthesiologists and Pathologists will be paid at the in-network level, subject to the Reasonable and Customary Fee, as long as all related services are provided in connection with covered services ordered by a Preferred Provider or provided during a covered Preferred Provider facility stay or visit.]

[Benefits payable for out-of-network [Radiologists,] [Anesthesiologists,] [Pathologists,], [hospital based Physicians,][and][assistant surgeons,] will be paid at the in-network level, subject to the Reasonable and Customary Fee, as long as the services provided are covered services ordered by a Preferred Provider or are covered services provided during a covered Preferred Provider facility stay or visit.]

C. CONDITIONS

(1) You are not required to seek treatment from a Preferred Provider. Each person is free to elect the services of a provider and benefits payable will be made in accordance with the terms and conditions of the rider.

(2) We make no representation or warranty as to the medical competence or ability of a Preferred Provider, or to their respective staff or physicians. We shall have no liability or responsibility, either direct, indirect vicarious or otherwise, for any actions or inactions, whether negligent or otherwise, of the Preferred Provider, their staff or physicians.]

PRESCRIPTION DRUG CARD BENEFIT

The Deductible and [Insured Percent][Coinsurance] of the Comprehensive Medical Benefit [do not] apply to this Prescription Drug Benefit.

A. DEFINITIONS

Copay(s): The amount of expenses for Prescription Drugs that must be incurred by each Covered Person , each time a prescription is filled or refilled, before benefits are payable. The Copays, if any, are shown on the Schedule of Benefits.

Emergency: A situation due to an Injury or a medical condition, which reasonably requires the Covered Person to seek immediate medical care under circumstances or at locations which reasonably prevent him from obtaining Prescription Drugs from a Member Pharmacy.

[Formulary: A list of drugs that have been selected for therapeutic efficacy and best cost values and are considered the agents of choice for a Physician to prescribe.]

[**Maintenance Drugs:** Prescription Drugs taken for a medical condition on a regular, routine or long term basis for care and treatment of chronic conditions which require that the dosage remain unchanged for more than [30days] Specialty Drugs are not considered Maintenance Drugs.].]

Member Pharmacy: A Pharmacy which is under an appropriate contract with a pharmacy benefit manager used with the Prescription Drug benefit. [A Member Pharmacy is [not]a Preferred Provider.]

Non-Member Pharmacy: A Pharmacy which is not under an appropriate contract with a pharmacy benefit manager. used with the Prescription Drug Card benefit. [A Non-Member Pharmacy is not a Preferred Provider.]

[Non-Preferred Drug: A Formulary Prescription Drug that is part of a therapeutic class on the preferred drug list (PDL) which does not offer the best efficacy and cost effectiveness over other products in the same class or it is a product that is not listed on the Formulary.]

Pharmacy: A licensed establishment where prescription drugs are dispensed by a pharmacist licensed under the law of the state where such pharmacist practices.

[Preferred Drug: A Formulary Prescription Drug that is within a select subset of therapeutic classes constituting the preferred drug list (PDL) which offers the best efficacy and cost effectiveness over other products in the same class. Covered Preferred Drugs are shown on the PDL furnished by the provider of the identification card used with this Prescription Drug Card benefit.]

[Preferred [Performance] Drug List (PDL): A subset of the Formulary. The PDL is not a complete Formulary but a list of Prescription Drugs from the standard Formulary that are cost effective in selected therapeutic classes. This list may not include all drugs for treatment of every illness.]

[Prescription Deductible: The amount, if any, for Prescription Drugs that must be incurred by each Covered Person insured in a [calendar Year][Plan Year], before benefits are payable in addition to the Deductible. The Prescription Deductible, if any, is shown on the Schedule of Benefits.]

[Prescription Drug[Coinsurance][Out-of-Pocket] Limit: The maximum amount of Covered Charges for Prescription Drugs [on each prescription Drug and each refill] which a Covered Person must pay each [calendar Year][Plan Year]][for each prescription] as shown on the Schedule of Benefits[**,** after application of [Prescription Drug Copay[s]] [, Prescription Drug Coinsurance] [and] [[Prescription] Deductible[s]]].]

[Preventive Prescription Drug: A drug that is both listed on the Preventive Prescription Drug List and that is prescribed: (1) for a person who has developed risk factors for a disease that has not yet manifested itself or become clinically apparent; (2) to prevent the reoccurrence of a disease from which a person has recovered; or (3) as part of a treatment plan for services that have been classified by the Internal Revenue Service, or successor organization, as preventive care [**,** however drugs used in treatment plans for weight loss and cessation of tobacco use are not eligible for coverage]. A Preventive Prescription Drug does not include a drug intended to treat an existing illness, injury or condition.]

[Preventive Prescription Drug List: A list of drugs that may be considered Preventive Prescription Drugs. A drug listed on the Preventive Prescription Drug List does not automatically qualify as a Preventive Prescription Drug.]

[**B. IDENTIFICATION CARD**
Each Insured will be given an identification card, or two cards will be given per family. The Covered Person must show this card each time he buys a Prescription Drug at a Member Pharmacy. He does not have to file a claim for benefits. The Member Pharmacy will keep track of any required [calendar Year][Plan Year] Prescription Deductible which the Covered Person must pay, and the individual Copays, if any, required for each prescription. If a Prescription Drug is bought at a Non-Member Pharmacy, the Covered Person must pay the entire cost of the drug and file a claim for benefits. The benefit may, in such cases, be lower than if he had bought the drug at a Member Pharmacy and shown his card.]

[C.] BENEFITS

[Benefits are considered for Prescription Drugs when subject to the Prescription Deductible, Copay and Reasonable and Customary Fee where applicable.]

In the event of an Emergency, benefits for Prescription Drugs obtained from a Non-Member Pharmacy will be paid as if they were purchased at a Member Pharmacy.

[A Member Pharmacy will accept payment of the Prescription Deductible as full payment for Prescription Drugs if the Covered Person shows his identification card at the time of filling the prescription. The Prescription Deductible and/or Copay are shown on the Schedule of Benefits.]

[Preventive Prescription Drugs obtained at a Member Pharmacy are not subject to the Deductible. Any Prescription Drug Copay for Preventive Prescription Drugs will apply to the In-Network/Out-of-Pocket Limit.]

[If the Covered Person does not show his identification card, or if he buys a Prescription Drug at a Non-Member Pharmacy, he must pay the entire cost of the drug and file a claim for benefits. The claim must be submitted on a form approved by Us. Benefits may not be assigned to a Non-Member Pharmacy, and any such attempted assignment shall be void. If a

Prescription Drug is purchased without use of the identification card [during the first 30 days that a person is covered under this Prescription Drug Benefit,] benefits will be paid for actual charges, up to the Reasonable and Customary Fee, [reduced by the Prescription Deductible]. The Covered Person must file a claim for benefits.]

[If a Covered Person incurs Covered Charges in the last [3 months] of a Year which are used toward meeting the Prescription Deductible, the amount of such charges will also be used toward meeting the Prescription Deductible for the next Year.]

[No more than a [30 day] supply [or 100 unit doses, whichever is less] will be covered each time a prescription is filled or refilled. Up to [two] [30 day] supplies of Maintenance Drugs may be filled at a Member Pharmacy. Limits on quantities and days supply may apply to certain therapeutic drug classes. [Subsequent refills of a Maintenance Drug must be submitted through the mail service program.]]

[No more than a [30 day] supply will be covered each time a prescription is filled or refilled at a Member Pharmacy. Maintenance Drugs may be filled as follows:

1. [30 day] supply at a Member Pharmacy; or
2. up to [30 day] supply through the mail order service program.

Limits on quantities and days supply may apply to certain therapeutic drug classes.]

[No more than a [30 day] supply of Prescription Drugs, filled or refilled, will be covered within the [30 days] immediately preceding the termination of this plan.] [In the case of overpayment a refund will be requested from the Insured.]

[[No more than a [30 day] supply will be covered each time a prescription is filled or refilled when the prescription is for a Specialty Drug.] [Specialty Drugs are only available from Our Member Pharmacy for Specialty Drugs.]]

If You or Your Physician specifically request a Brand Name Drug when a Generic Drug is available, You will be responsible for the Generic Drug Copay plus the difference between the cost of the Brand Name Drug and the Generic Drug.

[The Prescription Drug[Coinsurance/Out-of-Pocket] Limit must be met [each [calendar Year][Plan Year]][for each prescription] as shown on the Schedule of Benefits. The Prescription Drug[Coinsurance/Out-of-Pocket] Limit does not include [Copay[s]] [, Prescription Drug Coinsurance] [or] [[Prescription] Deductible[s]]]. When the Prescription Drug[Coinsurance/Out-of-Pocket] Limit] is reached, Prescription Drugs will be paid at 100% until the [end of the calendar Year][Plan Year][next prescription for the same drug is filled or refilled], except as otherwise noted.]

[D.] EXCLUSIONS AND LIMITATIONS

The exclusions of the Comprehensive Medical Benefit Section apply. In addition, no benefits are paid, unless specified elsewhere in this Certificate, for:

1. Drugs which do not meet the definition of Prescription Drugs;
2. Any drug containing nicotine for the purpose of use as a smoking deterrent, or other smoking deterrent medications;
3. [Minoxidil (Rogaine) for the treatment of alopecia;][
4.]Anorectics (any drug used for the purpose of weight control);[

[5.] [Infertility medications][;][

5.]Non-legend drugs other than those specifically listed as covered;[
6.]Charges for the administration or injection of any drug;[
8.]Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except as otherwise specified;[
9.]Prescriptions which a person is entitled to receive without charge under any Worker's Compensation Law;[
10.]Drugs labeled "Caution-limited by federal law to investigational use," or experimental drugs, even though a charge is made to the person;[
11.]Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one Year from the Physician's original order;[
12.]Medication which is to be taken by or administered to a person, in whole or part, while he is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;[
13.]Immunization agents, biological sera, blood or blood plasma;[and][
14.]Charges that exceed the Reasonable and Customary Fee[;and][
15.]Drugs related to any sex transformation or the reversal thereof [; and][

15.][Any drug used to block the enzyme that stimulates hair growth or otherwise slows or retards hair growth, including Minoxidil (Rogaine) for the treatment of alopecia[; and/.][

16.][Imported Drugs][; and][

17.][Specialty Drugs][not obtained through Our Member Pharmacy for Specialty Drugs][; and][

18.][Drugs, therapies and treatment for the restoration or enhancement of sexual activity [for any person age 18 or less.][

19.][Contraceptives, oral or other, whether medication or device, regardless of intended use.]

[E. PRIOR AUTHORIZATION

Some Prescription Drugs require prior authorization to be covered. If this is the case, the pharmacist will inform the Physician. The Physician will contact the pharmacy benefit manager to discuss the Medical Necessity of the prescription.

[When a Covered Person submits a request for a Prescription Drug at a Member Pharmacy or through Mail Order service, a more cost effective drug in the same therapeutic class may be recommended by the pharmacist. If a more cost effective drug in the same therapeutic class is available, You or Your pharmacist should contact Your Physician. Only Your Physician can approve and change Your prescription.

If the Covered Person does not purchase the more cost effective drug, he will be responsible for payment of [the full amount of the less cost effective drug] [the cost of the Prescription Copay amount for the less cost effective drug plus the cost of the difference between the more cost effective drug and the less cost effective drug] unless prior authorization has been received from Us. The more cost effective drug will not be dispensed without authorization from the prescribing Physician.]

If the prior authorization for the prescription is granted, the pharmacist will be notified of the approval. If approval is not granted, the Covered Person can contact Us to begin the appeal process. If approval is denied a second time, the Covered Person may contact Us for further appeal.

Drugs which are not yet available or which have not yet been created may be excluded. Please call the phone number listed on the Identification Card to verify if such drug is covered.]

TRANSPLANT BENEFIT

This Benefit Applies Only If The Schedule Of Benefits Shows That You Have Comprehensive Medical Coverage.

A. DEFINITIONS

Approved Transplant: A human organ or bone marrow transplant procedure currently performed at a Designated Transplant Facility.

Approved Transplant Services: Medically Necessary services and supplies which are related to an Approved Transplant procedure; are approved in writing under the Pre-certification process; and include but are not limited to:

1. pre-transplant patient evaluation for the Medical Necessity of the transplant;
2. Hospital charges;
3. Physician charges;
4. tissue typing and ancillary services; and
5. organ procurement or acquisition.

Designated Transplant Facility: A facility which has an agreement with Us to render Approved Transplant Services to Covered Persons. This agreement will be made through a national organ transplant network and may not be located in the person's geographic area.

Non-designated Transplant Facility: A facility which does not have an agreement with Us to render Approved Transplant Services to Covered Persons.

Transplant Benefit Period: The period of time from the date the person receives prior authorization and has an initial evaluation for the transplant procedure until the earliest of:

1. one year from the date the transplant procedure was performed;
2. the date coverage under the Comprehensive Medical Benefit Section terminates; or
3. the date of the Covered Person's death.

If, during the same admission as the initial transplant a retransplant occurs, the period of time is one year from the date of the initial transplant. If a retransplant will be done during a subsequent admission, a new Transplant Benefit Period starts from the date the person receives authorization for the transplant.

B. DESIGNATED FACILITIES FOR APPROVED TRANSPLANT SERVICES

This provision only applies to transplant procedures listed in the definition of Approved Transplant.

Transplant procedures must have prior authorization. The Covered Person or his Physician must call the toll free number provided to the Insured for this purpose. Retransplantation procedures must also have prior authorization.

If the Physician and We do not agree that the transplant procedure is Medically Necessary, the Covered Person will be informed, in writing of the right to a second opinion. A Board Certified Specialist will be provided for this second opinion.

A person who will be undergoing a transplant procedure will be referred to a Designated Transplant Facility. If the person is denied the procedure by the Designated Transplant Facility, he will be referred to a second such facility for evaluation. If the second facility determines, for any reason, that the person is not an acceptable candidate for the procedure, no benefits will be paid for any services or supplies related to that procedure. This applies regardless of whether the services or supplies are provided at a third Designated Transplant Facility or at a Non-designated Transplant Facility.

C. BENEFITS

Benefits for Approved Transplant Services provided during a Transplant Benefit Period will be paid as shown in the Schedule of Benefits. Benefits will be different for services provided at a Designated Transplant Facility than services provided at a Non-designated Transplant Facility. Other transplant procedures will be considered for benefit payment according to the provisions of this Certificate for any other surgical procedures.

Benefits will be paid for expenses incurred for Approved Transplant Services done at a Designated Transplant Facility for:

1. organ procurement or acquisition;
2. reasonable and necessary lodging and meal expenses incurred near the facility by the patient and by one companion accompanying him; and
3. air ambulance or other emergency transportation to, but not from, a Designated Transplant Facility, when necessary and approved, up to the limits shown in the Schedule of Benefits.

These limits apply, in the aggregate, to all amounts paid for lodging, meals and transportation for the patient and a companion.

The benefits listed above will be paid as shown in the Schedule of Benefits for procedures done at a Non-designated Transplant Facility. The organ transplant limitations will apply.

HIGH DOSE CHEMOTHERAPY FOLLOWED BY STEM CELL INFUSION OR AUTOLOGOUS OR ALLOGENIC BONE MARROW TRANSPLANT

High Dose Chemotherapy (HDC) followed by Stem Cell Infusion (SCI) will only be covered when Medically Necessary for neuroblastoma, acute leukemia in remission, resistant non-Hodgkin's lymphomas, advanced Hodgkin's disease, aplastic anemia, leukemia, hemoglobinopathies, metabolic storage disease, severe combined immunodeficiency disease (SCID), or treatment of Wiskott-Aldrich syndrome.

High Dose Chemotherapy followed by an Autologous Bone Marrow Transplant (ABMT) will only be covered when Medically Necessary for neuroblastoma, acute leukemia in remission, resistant non-Hodgkin's lymphomas, or advanced Hodgkin's disease.

High Dose Chemotherapy followed by an Allogenic Bone Marrow Transplant (ABMT) will only be covered when Medically Necessary for aplastic anemia, leukemia, hemoglobinopathies, metabolic storage disease, severe combined immunodeficiency disease (SCID), or treatment of Wiskott-Aldrich syndrome.

We will provide benefits for a Covered Person for covered HDC followed by SCI or ABMT up to the maximum amount shown on the Schedule of Benefits for this benefit.

The HDC/SCI/ABMT benefit period starts 5 days before the date the procedure is done and ends 12 months after the procedure is done. Only charges incurred during the HDC/SCI/ABMT benefit period will be considered for payment.

It is important to notify Us before such procedure is done to make certain that it will be covered. The Physician must submit a complete medical history including current diagnosis. The Physician must certify that the procedure is Medically Necessary and that alternative procedures, services or courses of treatment would not be effective in the treatment of the patient's condition.

D. EXCLUSIONS

No benefits will be paid for any service:

1. related to the transplantation of any non-human organ or tissue;
2. for a facility or Physician outside the United States of America;
3. which are eligible to be repaid under any private or public research fund, whether or not such funding was applied for or received;
4. which results from complications of Approved Transplant Services unless such complications are determined by us to be the immediate and direct result of Approved Transplant Services; or
5. for High Dose Chemotherapy (HDC) followed by Stem Cell Infusion (SCI) or Autologous or Allogenic Bone Marrow Transplant (ABMT) except as described above.

C. TERMINATION OF COVERAGE

1. Your coverage under a Benefit Section will end:

    a. if You do not pay, when due, any required contributory premium;
    b. if You ask to end Your coverage;
    c. when You become a member of any military, naval or air force on active duty;
    d. when any continuation of coverage ends, if You do not return to work for the Participating Employer;
    e. when the date the Benefit Section terminates, except for any extended benefits;
    f. on the last day of the month in which Your work terminates;
    g. at the end of a 6-month period in which you are not actively at work due to disability..

2. A Dependent's coverage under a Benefit Section will end:

    a. If You do not pay, when due, any required contributory premium for the Dependent's coverage.
    b. If You ask to end his coverage;
    c. the Dependent becomes a member of any military, naval or air force on active duty;
    d. when Your coverage terminates;
    e. when his status as a Dependent ends;
    f. when Dependent's coverage terminates for his Insurance Class;
    g. when the Benefit Section terminates, except for any extended benefits;

D. RESUMPTION OF COVERAGE

Coverage which ends due to leave of absence or layoff of not more than 6 months may be resumed on the first day of the month following the date You return to full time work, if You are otherwise eligible and Your premium is paid. **For coverages other than Comprehensive Medical**, if You are not at work, or are disabled, on the date coverage would resume, the resumption of coverage will be delayed until You are at work. **For coverages other than Comprehensive Medical**, if a Dependent is confined in a hospital or unable to do his normal activities on the date coverage would resume, the resumption of his coverage will be delayed until he is released from the Hospital and he is also released by his attending Physician to do, and in fact does, his normal activities. If You return to work after leave of absence or layoff of more than 6 months You must apply in writing for coverage and complete the required length of service as if You were a new employee.

E. REPORTING OF ELIGIBLE EARNINGS

1. Your employer will report to Us the amount of Your Eligible Earnings when You apply for any benefits related to salary. The amount of reported earnings will be used to determine the amount of those benefits until the next following anniversary of the employer's participation.

2. Your employer will thereafter report Eligible Earnings annually before each anniversary of his participation. Reported Eligible Earnings will be used to determine the amount of Your benefits during the 12 month period starting on each such anniversary.

3. "Eligible Earnings" means only:

    a. Your regular salary or wages as last reported by Your employer; plus
    b. the average rate of commission payments that has been or is reasonably expected to be paid to You by Your employer, as last reported.

Overtime, bonuses, and other special pay are excluded from the calculation of Eligible Earnings.

3. PROOFS OF LOSS

For Basic or Long Term Disability Benefits, written proof of loss must be given within 90 days after the end of each period for which benefits are payable. For any other loss, written proof must be given within 90 days after the loss. If it was not reasonably possible to give written proof in the time required, the claim will not be reduced or denied for this reason if the proof is filed as soon as reasonably possible. The proof required must be given no later than [12] months from the time specified, unless the claimant was legally incapacitated.

4. TIME OF PAYMENT OF CLAIMS

After written proof of loss is received, any monthly or weekly benefits then due for disability will be paid. Benefits for any other covered loss will be paid as soon as written proof is received.

5. PAYMENT OF CLAIMS

We may, at our option, choose to make payment directly to the Hospital or person providing a covered service. We will do this unless You tell us otherwise, in writing, and not later than when You file proof of loss with us. In the case where a Dependent child is in the custody of a person other than the Insured, we may make payment to the custodian of the child, at our discretion or as required by law. Any benefits unpaid at death will be paid either to Your estate or under the "Facility of Payment" provision. Other benefits will be paid to You.

6. BENEFITS PAYABLE

Total benefits paid will never exceed actual expense incurred.

7. MULTIPLE PROCEDURE BILLING PRACTICES

When certain medical procedures are performed, other procedures may be performed at the same time, as component parts of the primary procedure and should be billed as part of the primary procedure, based on the National Correct Coding Initiative issued by the Center for Medicare and Medicaid Services or other resources as determined by Us. If the provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

In cases where separate benefits are warranted when more than one surgical procedure is performed on the same day and at the same operative session, the total benefit payable for such surgical procedures will be 100% of the Covered Charge for the primary procedure and [50%] of the Covered Charge for the second through fifth procedures. All remaining procedures will be covered at no less than [25%] of the Covered Charge. [This evaluation may be applied to Covered Charges submitted by Preferred Provider and Non-Preferred Providers.]

8. UNBUNDLING

When certain complicated Medical and Dental procedures are performed, other less extensive procedures may be performed at the same time, as component parts of the primary procedure. For benefit purposes, these less extensive procedures are considered to be integral components of the primary procedure. Even if the provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure, as determined by Us.

C. FACILITY OF PAYMENT - FOR ALL BENEFITS OTHER THAN LIFE BENEFITS

If benefits are payable to Your estate, up to [$1000.00] of benefits may be paid to someone related to You by blood or marriage who is considered to be entitled to the benefits. If You are physically, mentally, or otherwise incapable of giving a valid release for any payment, up to [$1000.00] of benefits may be paid to someone related to You by blood or marriage, or to any person or institution which has assumed financial responsibility for Your affairs.

MISCELLANEOUS PROVISIONS

A. A copy of the Contract will be kept at the principal office of Starmark. You may inspect the Contract during regular business hours.

B. The Contract may be amended on the anniversary of the Participating Employer's participation in the group health plan or as required by law at any time without Your consent or notice to You. Amendment of the Contract will not affect a claim starting before the effective date of the amendment.

C. **Reimbursement**

You shall, on behalf of yourself and Your Dependents, if any, reimburse us for benefits provided or paid for, for which a person was not eligible under the terms of this Certificate. You must pay us back as soon as we notify You and request the reimbursement. At our option, we may reduce or refuse payment for subsequent requests for benefits as a set-off toward such reimbursement. The acceptance of premium or other fees or the providing or paying of benefits by us shall not constitute a waiver of our rights to enforce these provisions in the future. This provision shall be in addition to, and not in lieu of, any other remedy available to us at law or in equity.

D. We will pay benefits upon receipt of proof of loss. All proof of loss must be satisfactory to Us. The proof of loss must describe the event, the nature and the extent of the cause for which a claim is made.

[E.] Incentives, Rebates and Contribution

We may elect to furnish, or provide Covered Persons access to programs in addition to the benefits described under Covered Charges. In addition, We may elect to participate in programs provided by other organizations that furnish discounts on services or where other items of value may be offered. The cost for such programs, which may be included in your premium, may be discounted, credited, waived or otherwise adjusted. Such discounts, credits, waivers, adjustments or other items of value will not be conditioned on a health-status related factor. We are not liable for the negligent provision of any goods, services or discounts provided through a vendor.

MEDICARE

These provisions apply to Comprehensive Medical Benefits.

1. This subsection applies to: (1) Insureds who are at least 65 years of age; and (2) the spouse of an Insured when the spouse is at least 65 years of age.

    a. Benefits will be paid secondary to Medicare when Your employer has less than 20 employees. Covered Charges will be reduced by any benefits payable by Medicare.
    b. When Your employer has 20 or more employees and is subject to the Social Security Act (Section 1862 (b)), Comprehensive Medical Benefits will be paid primary to Medicare. This will result in an increase in premium. You may choose to voluntarily waive coverage under this plan and elect Medicare as sole payor.

2. If Your employer has 100 or more employees, and You maintain employee status as determined by the guidelines issued by [the Center for Medicare and Medicaid Services (CMMS)], benefits will be paid primary to Medicare for You or Your Dependent who is eligible for Medicare due solely being entitled to Social Security Disability Income Benefits.]

3. Benefits will be paid primary to Medicare if You or Your Dependent are entitled to Social Security benefits solely on the basis of end stage renal disease, but only during a period of up to [30 consecutive months]. The [30 month] period begins with the earlier of:

    a. the month in which a regular course of renal dialysis is initiated; or
    b. in the case of a person who receives a kidney transplant, the first month in which the person becomes entitled to Medicare.

After [30 consecutive months], benefits will be paid secondary to Medicare.

Except with respect to C. as provided above, benefits will be paid secondary to Medicare whether or not the Covered Person actually enrolls for Medicare parts A, B and or D.

[B. (2) CONTINUATION OF COVERAGE FOLLOWING TERMINATION OF DEPENDENT CHILD STATUS

This continuation of coverage applies only after a Dependent has been continuously covered under the Comprehensive Medical Benefit, and any similar group coverage provided by Your employer which it replaced, for 3 months.

Your employer will offer to continue any Comprehensive Medical coverage in force for Your Dependent child on the date such child is no longer eligible as a Dependent because of the limiting age for Dependent coverage.

Coverage will not be continued for a Dependent child who:

1. is covered by a comparable group plan; or
2. exercises the conversion privilege.

Coverage may be continued for 6 months. Premium charged shall be the same as the rate applicable to a current Insured. Premium must be paid to the employer on a monthly basis.

Continued coverage will end at the earliest of:

1. the end of a 6-month period;
2. the end of the period for which premium is paid;
3. the date the employer terminates coverage herein;
4. the date the Benefit terminates;
5. the date the Dependent becomes covered by a comparable group plan; or
6. the date the Dependent marries.

To elect continuation coverage, the Dependent must make a written request to Us within 10 days of reaching the limiting age. The Dependent must pay the initial premium within 30 days after receipt of a notice of premium due. Failure to submit a written request or pay the initial premium within the times provided shall terminate this continuation privilege.

At the end of any continuation period, the Dependent may exercise the conversion privilege unless the continuation period ended because the employer terminated coverage or the Dependent became covered under a comparable group plan.]

Starmark

Fully insured by Trustmark LIFE INSURANCE COMPANY

Employee Enrollment Form

To be completed by the EMPLOYEE ONLY. Print legibly in ink only. NOTE: If you make a mistake when completing an answer, please correct, initial and date. NOTICE: A person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines, confinement in prison, and may result in rescission of coverage.

Employer Information

COMPANY NAME	LOCATION (State, ZIP)	GROUP NUMBER (if available)
PLAN CHOICE (if available): DEDUCTIBLE	PHYSICIAN/HOSPITAL NETWORK	PROPOSED EFFECTIVE DATE

Employee Information (All full-time employees must complete this section.)

LEGAL FIRST NAME	MIDDLE INITIAL	LEGAL LAST NAME	
ADDRESS	CITY	STATE	ZIP

SEX ☐MALE ☐FEMALE	SOCIAL SECURITY NUMBER	BIRTH DATE (mm/dd/yyyy)	MARITAL STATUS ☐ SINGLE ☐ MARRIED

WORK PHONE	HOME PHONE	E-MAIL ADDRESS

DATE EMPLOYED FULL TIME (mm/dd/yyyy	JOB TITLE	HOURS WORKED PER WEEK	ANNUAL SALARY $

Beneficiary Information (if applicable)

Beneficiary Name: First	M.I.	Last	Relationship

Coverage Information

Please check the appropriate boxes under either the "Applying for Coverage" section or the "Waiving Coverage" section. **NOTE:** If you are declining coverage and choose to apply for coverage in the future, you or your dependents may be considered late enrollees. Please see information regarding pre-existing conditions.

Applying for Coverage	**Waiving Coverage**
I am applying for coverage for:	I am declining coverage for:
Coverage Applying for (Check only one): ☐ Employee only ☐ Employee and Spouse/[Domestic Partner] ☐ Employee and Child(ren) ☐ Employee, Spouse/[Domestic Partner] and Child(ren) Reason for enrollment (Check only one): ☐ New Group Plan ☐ New Hire ☐ Plan Change ☐ Late Enrollment ☐ Special Enrollee (include Special Enrollee Form AD41) If no longer employed, but on COBRA or State Continuation enter employment termination date (mm/dd/yyyy):_____	☐ Declining **all** group coverage offered by my employer at this time: ☐Employee ☐Spouse/[Domestic Partner] ☐Child(ren ☐ Declining **medical** coverage for: ☐ Employee ☐ Spouse/[Domestic Partner] ☐ Child(ren) ☐ Declining **dental** coverage for: ☐ Employee ☐ Spouse/[Domestic Partner] ☐ Child(ren) I have been offered medical coverage and wish to decline for the following reasons (check one below): ☐ Covered by spouse's/[domestic partner's] group health plan ☐ Government plan: ☐ Medicare ☐ Medicaid ☐ State plan ☐ Individual Medical Plan ☐ Not Affordable ☐ **COBRA/State Continuation*** ☐ Other (explain): _____ Employee Signature: (if waiving coverage) Signature: _____ Date: _____ *NOTE: If you are declining coverage for any reason other than COBRA/State Continuation please complete this section, sign above and return the application. If you are declining coverage due to COBRA/State Continuation, please complete the entire enrollment form.

OFFICE USE ONLY

UND _____ EFF _____ SUB _____

Dependent Information

List the dependents to be covered. NOTE: If you are waiving coverage for your dependents, please complete the **Coverage Information** section on the first page.

SPOUSE/[DOMESTIC PARTNER] LEGAL FIRST NAME	LEGAL LAST NAME	BIRTH DATE(mm/dd/yyyy)	SOCIAL SECURITY NUMBER	SEX ☐ M ☐ F
CHILD LEGAL FIRST NAME	LEGAL LAST NAME	BIRTH DATE(mm/dd/yyyy)	SOCIAL SECURITY NUMBER	SEX ☐ M ☐ F
CHILD LEGAL FIRST NAME	LEGAL LAST NAME	BIRTH DATE(mm/dd/yyyy)	SOCIAL SECURITY NUMBER	SEX ☐ M ☐ F
CHILD LEGAL FIRST NAME	LEGAL LAST NAME	BIRTH DATE(mm/dd/yyyy)	SOCIAL SECURITY NUMBER	SEX ☐ M ☐ F

Prior/Other Coverage

Did you or any dependent(s) enrolling on this form have prior major medical coverage within the last 12 months? ☐Yes ☐No
If "yes," please complete the following section:

Prior Carrier Name _____ Start Date ___/___/___ End Date ___/___/___

Who was covered? ☐ Employee . ☐ Spouse/[Domestic Partner] . ☐ Child(ren)

Do you or any dependent(s) enrolling on this form have existing major medical coverage that will be in effect on the day this coverage begins? ☐ Yes ☐ No If "yes," please complete the following section:

Name of Other Carrier _____ Start Date ___/___/___

Who Is covered? ☐ Employee . ☐ Spouse/[Domestic Partner] . ☐ Child(ren)

[Medical Information

Section A: The following questions apply to all enrolling (this includes employees, dependents and individuals on COBRA/State Continuation)

Have you or your spouse/[domestic partner] who will be covered used any tobacco products in the past 12 months?
Employee: ☐ Yes ☐ No
Spouse/[Domestic Partner]: ☐ Yes ☐ No

EMPLOYEE'S HEIGHT	WEIGHT	SPOUSE/[DOMESTIC PARTNER]'S (if applicable) HEIGHT	WEIGHT

1. Within the last four years have you or any dependents who will be covered, consulted, received treatment or been advised to have treatment, had medication prescribed, or been diagnosed for any of the following? ☐ **Yes** ☐ **No**
If "yes," check all that apply:

A.☐ alcohol or drug use
B.☐ arthritis
C.☐ autoimmune disorder or systemic disease
D.☐ back
E.☐ cancer or tumor
F. ☐ diabetes
G.☐ growth disorder or other endocrine/hormone disorder
H.☐ heart or circulatory (other than high blood pressure)
I. ☐ muscular or joint
J. ☐ kidney
K.☐ liver
L. ☐ lupus
M.☐ mental or emotional disorder, including ADHD/ADD
N.☐ colon or intestinal
O.☐ respiratory
P. ☐ reproductive disorder
Q.☐ neurological or stroke

2. Are you or any dependents who will be covered pregnant? ☐ **Yes** ☐ **No** If "yes," due date? _____

3. Have you or any dependent who will be covered ever had a positive blood test indicating HIV antibodies or been treated and/or advised by a medical practitioner as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or any other immune system deficiency? ☐ **Yes** ☐ **No**

4. Have you or any dependent who will be covered been hospitalized, had surgery, had more than $5,000 in medical expenses in the last 12 months or been advised that hospitalization or surgery is necessary? ☐ **Yes** ☐ **No**

Section B: The following questions apply to **ALL** individuals for new groups with **LESS THAN 10** medical lives and to **ALL NEW ENROLLEES FOR INFORCE GROUPS.**

5. Within the last 4 years, have you or any dependent received or been scheduled to have treatment and/or medication(s) for, consulted a physician or other medical professional, or had any test performed for any disorders or conditions of the following? ☐ **Yes** ☐ **No** **If yes, please check all that apply.**

☐ ear ☐ eye ☐ hernia ☐ thyroid ☐ urinary tract ☐ allergy ☐ digestive system
☐ headache ☐ breast ☐ asthma ☐ rectal ☐ high blood pressure ☐ prostate ☐ ulcer

6. Within the last 4 years, have you or any dependent received treatment and/or medication(s) or been advised to receive treatment for any reason not already mentioned? ☐ **Yes** ☐ **No**

Please provide complete details to all medical questions that have been checked or answered "Yes" on Page 3.]

[Medical Information

Employee Name:____ Group: ________________________________

Please provide details for each YES answer on Page 2 of the enrollment form. If more space is needed, attach a separate sheet, sign and date it.

Question Number __________

Person with condition: ______________________________ **Exact Diagnosis:** _____________________________

Date diagnosed: ___________________________________ **Date last treated:** ______________________________

List all medications prescribed for this condition:	**Dosage:**	**Frequency:**	**Currently taking?**
________________	________	________________	☐Y ☐N
________________	________	________________	☐Y ☐N
________________	________	________________	☐Y ☐N

List all treatment received for this condition: ____

List all tests received for this condition:_____________________ Readings and results: ______________________

Any relapses or flare-ups? ☐**Yes** ☐**No** **Date(s):** ____

What future test, treatment, surgeries have been recommended? ____

Anticipated Date(s): ____

Prognosis:____ Date last treated:___________________________

Question Number __________

Person with condition: ______________________________ **Exact Diagnosis:** _____________________________

Date diagnosed: ___________________________________ **Date last treated:** ______________________________

List all medications prescribed for this condition:	**Dosage:**	**Frequency:**	**Currently taking?**
________________	________	________________	☐Y ☐N
________________	________	________________	☐Y ☐N
________________	________	________________	☐Y ☐N

List all treatment received for this condition: ____

List all tests received for this condition:_____________________ Readings and results: ______________________

Any relapses or flare-ups? ☐**Yes** ☐**No** **Date(s):** ____

What future test, treatment, surgeries have been recommended? ____

Anticipated Date(s): ____

Prognosis:____ Date last treated:___________________________

Question Number __________

Person with condition: ______________________________ **Exact Diagnosis:** _____________________________

Date diagnosed: ___________________________________ **Date last treated:** ______________________________

List all medications prescribed for this condition:	**Dosage:**	**Frequency:**	**Currently taking?**
________________	________	________________	☐Y ☐N
________________	________	________________	☐Y ☐N
________________	________	________________	☐Y ☐N

List all treatment received for this condition: ____

List all tests received for this condition:_____________________ Readings and results: ______________________

Any relapses or flare-ups? ☐**Yes** ☐**No** **Date(s):** ____

What future test, treatment, surgeries have been recommended? ____

Anticipated Date(s): ____

Prognosis:____ Date last treated:___________________________

As part of our routine underwriting procedure, you may receive a telephone call from the home office to obtain additional information needed to evaluate your Enrollment Form. Providing additional medical information on this form will help reduce the need for a phone call. Your answers will be strictly confidential.

Signature:____ **Date:**___________________________________

SIGNATURE AND DATE ARE ALSO REQUIRED ON THE AGREEMENT AND AUTHORIZATION SECTION ON NEXT PAGE.]

AGREEMENT AND AUTHORIZATION

Unless waived on Page 1, I request insurance under my employer's insurance plan as it is now or as it may be amended in the future. I authorize my employer to make deductions from my earnings for my share of the cost, if any, for the benefits to which I may become entitled. I represent that all statements and answers made in this application or any medical questionnaires are complete and true, and I understand that answers will be the basis of any coverage issued. I also understand that all statements and answers made in this application will be valid for 60 days from the date signed.

I authorize Trustmark Life Insurance Company (Trustmark), its authorized representatives, its reinsurers and consumer reporting agencies, or any other authorized representatives, to obtain, use, and/or disclose certain information about me as indicated below.

Trustmark may obtain and maintain Protected Health Information (PHI) about me to perform specific functions. This Authorization describes the type of information that is collected and my rights regarding how that information can be used.

Protected Health Information (PHI) includes individually identifiable health information that is created or received by my provider, my health plan or insurer, a data clearinghouse, a health authority, employer, school or university. PHI can be maintained or transmitted in any form or medium. It relates to the past, present, or future:

- condition of my physical or mental health;
- health care provided to me; or
- payment for the health care provided to me.

PHI does not include summary health information or information that has been de-identified according to the standards for de-identification provided for in the HIPAA Privacy Rule.

This information may be obtained from a number of sources including, but not limited to, applications for health plan coverage, questionnaires, health care providers, claims for payment filed by myself or health care providers, referrals made by health care providers, and my medical records. Other sources of PHI include group health plan administrators, insurance carriers, the Medical Information Bureau, employers, and other business partners such as pharmacy benefit managers, third-party administrators, consultants, agents or brokers. PHI may be obtained over the telephone, by mail, or e-mail.

PHI may be used by Trustmark sales and underwriting personnel, legal, or others as may be necessary in order to provide insurance coverage. Additionally, PHI may be used by, and disclosed to other business partners, such as agents or brokers, for the purpose of determining eligibility for coverage.

Trustmark is committed to the privacy of your PHI and have required all business associates and vendors to agree in writing to those same protections. Despite these efforts, we are required by law to advise you that your information may at some point fall outside of these protections.

I understand I have a right to inspect and copy my own PHI to be used or disclosed. I also understand that failure to sign this Authorization will result in my application not being considered. I agree this Authorization will be valid until Trustmark has completed its determination of my eligibility for coverage. A simulated, faxed or copied image of this Authorization shall be as valid as the original.

If this Employee Enrollment Form was completed by electronic or telephonic means, I acknowledge that I have not myself actually signed the Employee Enrollment Form but instead I hereby authorize Trustmark or its Agent to print "Electronically Acknowledged" on the signature line of the Employee Enrollment Form and I agree that such printing shall be treated as a valid signature for all purposes of this form. I acknowledge that Trustmark or its Agent has verified my identity for this purpose in accordance with any applicable law or regulation. This Employee Enrollment Form is made part of the Employer Application.

Employee Signature _____ Date _____

Administered by

Starmark

400 Field Drive • Lake Forest, IL 60045-2581
www.starmarkinc.com

Fully insured by

Trustmark
LIFE INSURANCE COMPANY

Participating Employer Application and Agreement

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Instructions for completing this application and agreement:

1. The company officer and the writing agent must sign and date this application and agreement.
2. Attach a current copy of the employer's last state quarterly wage and tax statement.
3. Attach a copy of the most recent billing statement(s) from your previous carriers.
4. Attach a copy of the proposal indicating the employer's plan section(s) with this application.
5. Include a company business check for one month's premium made payable to Starmark.

Employer Information

FULL LEGAL NAME OF COMPANY		EMPLOYER TAX ID NUMBER
STREET ADDRESS (No PO boxes)	PHONE NUMBER	FAX NUMBER
CITY/STATE/ZIP	COUNTY	DATE BUSINESS STARTED (mm/yyyy)
NATURE OF BUSINESS		SIC CODE
COMPANY DESCRIPTION ☐ Proprietorship ☐ Partnership ☐ Corporation ☐ Other_____		
PLAN ADMINISTRATOR (Name and title)		E-MAIL ADDRESS

Are there any other physical locations (i.e., subsidiaries or affiliates) to be covered? ☐ Yes ☐ No
If "yes," complete the following section. If more space is needed, use a separate sheet, include all information that is required below, and attach it to this application. NOTE: The sheet must be signed and dated by a company officer.

FULL LEGAL NAME OF COMPANY		TAX ID NUMBER
STREET ADDRESS (No PO boxes)	PHONE NUMBER	FAX NUMBER
CITY/STATE/ZIP	COUNTY	DATE BUSINESS STARTED (mm/yyyy)
NATURE OF BUSINESS	COMMON OWNERSHIP? ☐ Yes ☐ No	SIC CODE
COMPANY DESCRIPTION ☐ Proprietorship ☐ Partnership ☐ Corporation ☐ Other_____		

Coverage Information

IMPORTANT: Coverage is not effective without written notification from Trustmark Life Insurance Company (Trustmark) or Star Marketing and Administration, Inc. (Starmark). Any existing coverage should remain in force until such written notification is received.

Requested **effective date** of insurance (mm/dd/yyyy): _____
If other than the first day of month, please explain why: _____
Number of **full-time and part-time** employees: _____
Number of **full-time** employees: _____
Number of **employees eligible** for plan: _____
Number of employees **covered under or in election period** of COBRA or state continuation: _____
Number of employees in their **waiting period**: _____
Carve Out? ☐ Yes ☐ No If "Yes", class to be covered: _____

Employer Name: _____

Coverage Information (continued)

NOTE: Any employees who are in their waiting period and eligible for coverage within 60 days of the group's effective date must submit a completed Employee Enrollment Form.

☐ Eligible employees will be insured the first day of the month following _____ days of continuous employment (waiting period).

☐ Waive the waiting period for all employees during the initial enrollment.

YES	NO	
☐	☐	1. Are there any employees who are not actively at work on the date of this application?
☐	☐	2. Are there any employees who have been absent from work 2 consecutive weeks in the past 12 months?
☐	☐	3. At any time during the past 24 months has your company had medical coverage terminated or a renewal of medical coverage refused?
☐	☐	4. During the last 12 months, has there been an increase or decrease of 10% or more in the number of employees?
☐	☐	5. During the last 12 months, has your company's turnover rate for employees exceeded 30%?

If "yes" to questions 1 through 5, please explain: _____

_____

If a plan compatible with a Health Savings Account (HSA) is selected, the employer will contribute to the account:

_____ per employee; _____ per family

If the employers intends to provide funds through a Health Reimbursement Arrangement (HRA), the employer will fund:

_____ per employee; _____ per family

For the HRA, will the employer allow funds to rollover? ☐ Yes ☐ No

Participation

Participation Requirements: Eligible employees and dependents may be able to waive medical and/or dental coverage and not be counted for participation requirements if they have comparable group coverage through their spouse and a minimum of 50 percent of all eligible employees have enrolled. **Attach a copy of your last state quarterly wage and tax statement.**

For medical coverage and all additional benefits, a minimum of 75% participation is required.
For Employee Life or Employee Long Term Disability coverage (without medical), 100% participation is required.
For Employee Dental coverage (without medical), 75% participation is required.

Contribution

Employer Contribution Requirements: Employer must contribute towards the overall cost of the group health plan. The minimum employer contribution is 25% of the total cost for employees and dependents or 50% of the total cost for employees.

EMPLOYER CONTRIBUTION FOR EMPLOYEES:	EMPLOYER CONTRIBUTION FOR DEPENDENTS:
_____ %	_____ %

Prior Coverage

NAME OF PREVIOUS MEDICAL GROUP CARRIER	NAME OF PREVIOUS DENTAL GROUP CARRIER
PRIOR MEDICAL COVERAGE HAS BEEN IN EFFECT SINCE:	PRIOR DENTAL COVERAGE HAS BEEN IN EFFECT SINCE:

Why are you leaving your current group carrier? _____

Premium renewal date with your current group carrier: _____

Attach a copy of the most recent billing statement(s) from your previous carrier(s).

Employer Name: _____

Billing

Employers with 10 or more eligible employees: Choose one billing methodology (assuming no change in demographic composition of the employer, both methods will result in the same premium). NOTE: Some states may require composite rating.

☐ Individual Billing – Each eligible employee is charged a rate that depends on the individual's demographic and family status.

☐ Composite Billing – Rating factors for all eligible employees are combined, and average amounts are charged for the four family categories of Employee Only, Employee and Spouse, Employee and Children, or Full Family.

PREMIUM BILLING TYPE:

☐ Monthly Premium Statement ☐ Electronic Funds Transfer (EFT) (Complete Authorization Form AD34)

"Bill to" Address (if different than Street Address):

If a "bill to" address is chosen, the following items will be sent to the **physical address:** certificates and ID cards, renewal packets, late payment reminders, nonpayment termination letters and all other correspondence. Items sent to the **billing address** are billing statements, late payment reminders and nonpayment termination letters.

NAME	BILLING ADDRESS	CITY	COUNTY	STATE	ZIP

"BILL TO" ADDRESS:

☐ Bill Payment Office ☐ Accountant ☐ Other _____

Automated Customer Environment (ACE)

The ACE system is Starmark's Automated Customer Environment – a complimentary, user-friendly system that is easily accessible through the Starmark website. ACE provides Starmark customers with immediate access to enrollment and billing information.

☐ Yes, I would like to sign up for ACE.

☐ No, I do not want to sign up for ACE.

ACE CONTACT (Name and title)	E-MAIL ADDRESS

SELECT THE DESIRED BILLING OPTION:

☐ **E-mail** the billing statement ☐ **Mail** the billing statement

Electronic Communications

Employer consents to accept an electronic file version of the Certificate(s) of Insurance provided by Trustmark, administered by Starmark, for electronic delivery to each covered employee. Employer further agrees that it is solely responsible for providing each covered employee electronic access to the most current version of any electronic file provided by Starmark to the employer. Upon request by a covered employee, a paper copy of the Certificate of Insurance may be obtained from Starmark.

Employer also consents to receive information regarding its coverage with Trustmark and services provided by Starmark, via e-mail. In addition, employer understands that Starmark has established a secure website through which authorized individuals can receive updated information about their coverage with Trustmark. Information on how to access the website will be given to all authorized individuals. Employer further understands that it can accept or decline to receive information through the website and receive all updated information in paper or non-electronic format. Employer also understands, that if it agrees to receive the information via the website, employer can at a later date withdraw its consent to receive information through the website.

☐ Accept ☐ Decline

Employer Name: _____

General Representations and Agreements

Eligible Employees: Employer certifies that it employs the number of full-time employees (30 hours or more per week; Ohio – 25 hours per week) as noted previously on this form and that no part-time employees are to be included for coverage. Employer agrees to make the benefit plans available to all present and future eligible employees, and understands that each employee must satisfy all eligibility requirements for insurance to become effective.

Effective Date: Employer understands that no **insurance will become effective without written notification by** Trustmark or its administrative representative, Starmark.

Medicare as Payor: Employer understands that medical benefits for employees or spouses who are age 65 and over will be paid secondary to Medicare when an employer has less than 20 employees. Covered charges will be reduced by any benefits payable by Medicare. When an employer has 20 or more employees, medical benefits will be paid primary to Medicare. An employee may choose to voluntarily waive coverage under the medical plan and elect Medicare as sole payor.

Termination: Employer understands that he may cancel his insurance at any time by giving 30 days advance written notice to Trustmark or to Starmark. Trustmark may cancel the employer's insurance only for stated reasons, such as inadequate participation or contribution; nonpayment of premium; or fraud.

Producer: Employer understands that the **producer** submitting this application represents the employer's interest, not that of Trustmark, and that the **producer has no right to bind coverage, to alter terms of the Group Insurance Contract or Application in any manner, or to adjust any claim for benefits under the Group Insurance Contract.**

Subscription to Trust: Employer hereby applies for participation in The Starmark MET Group Insurance Trust and for enrollment in the Group Insurance Contract established thereunder. The coverage(s) selected by Employer will be shown on a proposal.

Employer understands that: (a) as an employer, he is establishing this plan and that neither Starmark, the Policyholder Trustees, nor Trustmark are acting as "sponsor" or "plan administrator," as defined in the Employee Retirement Income Security Act of 1974 (ERISA) as amended; and (b) any compliance under ERISA that is applicable to the sponsor or plan administrator will be fulfilled by the employer, as its own legal counsel may determine. Employer understands that if it is subject to federal law which prohibits sex and age discrimination, it may have to choose pregnancy options or tailor its plans to comply, and/or seek legal counsel in this respect.

Employer agrees to be bound by the terms of the Group Insurance Contract and understands that any conflict will be resolved solely by reference to the Policy.

Employer agrees to promptly furnish Starmark, or Trustmark, with records or other information required to ensure proper administration of the insurance plans of The Starmark MET Group Insurance Trust and associated trusts.

Trustmark has the right to revise the rates (retroactively or prospectively) for the insurance coverage(s) or rescind or terminate the insurance coverage(s) if a person completes the Employee Enrollment Form with false, incomplete or misleading information resulting in a material misrepresentation affecting the assessment of the risk or the terms or conditions for coverage. Trustmark has the right to make any adjustment or denial of benefits due to the material misrepresentation.

Employer Name: _____

Plan Sponsor Certification

During the term of this group health benefit plan, the plan sponsor may receive Protected Health Information (PHI). As set forth in the HIPAA Privacy Rule (Rule), PHI includes individually identifiable health information and relates to the past, present or future:

- condition of an individual's physical or mental health;
- healthcare provided to an individual; or
- payment for healthcare provided to an individual.

The plan sponsor of a fully insured group health plan may choose not to receive PHI from us. If this selection is made below, the group health plan will be exempt from the administrative requirements of the HIPAA Privacy Rule. Whether or not the plan sponsor receives PHI from us, it must agree to safeguard and protect the confidentiality of any PHI you receive and to sign this Certification. The plan sponsor also agrees to amend the plan document of the group health plan consistent with this Certification.

EXEMPTION FROM ADMINISTRATIVE REQUIREMENTS

The group health plan may be exempt from the administrative requirements of the Rule if it does not create or receive PHI on plan participants, except for:

- summary health information (health information that does not identify the individual to whom it applies); or
- information on enrollment or disenrollment from the insurance health plan.

Administrative requirements include: assignment of privacy officer and contact person, employee training; safeguard protections for PHI; handling privacy complaints; sanctions for noncompliance with privacy policies and procedures; mitigation for harmful effects of use and disclosure in violation of privacy policies and procedures; developing privacy policies and procedures; creating Privacy Notice.

PLAN SPONSOR CERTIFICATION

The plan sponsor, or the designated representative of the plan sponsor, certifies that it will:

- Not use or disclose PHI for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan of the plan sponsor.
- Not use or disclose to anyone the PHI of any individual covered under this group health benefit plan other than as described in this Certification, and permitted or required by the HIPAA Privacy Rule and other applicable laws.
- Ensure that any agents, including subcontractors, to whom PHI is provided, agree to the same restrictions and conditions that apply to the plan sponsor in connection with the HIPAA Privacy Rule.
- Report to the group health benefit plan any use or disclosure of the information that is inconsistent with the uses or disclosures permitted or required by the HIPAA Privacy Rule and other applicable laws.
- Make available PHI as required in the Rule for Access of Individuals to their own PHI.
- Make available PHI as required in the Rule in order to amend PHI and incorporate any amendment to PHI in accordance with the Rule.
- Make available the information required to provide an accounting of disclosures of PHI as required by the Rule.
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the group health benefit plan available to the Secretary of the Department of Health and Human Services.
- Return or destroy, if feasible, all PHI received from the group health benefit plan that the plan sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- Provide a List of Authorized Representatives, which includes the identity or job title, and affiliation of persons required or permitted to receive information in order to perform services on behalf of the group health benefit plan (e.g. claim administrator, case management vendor, pharmacy benefit manager, claim subrogation vendor, claim auditor, provider network manager, utilization and review management vendor, stop loss insurance carrier, insurance broker/consultant), and any other entity subcontracted to assist in administrating the health plan.
- Provide PHI only to those individuals or entities identified on the List of Authorized Representatives.
- Provide an effective mechanism for resolving any issues of noncompliance with the provision of this Certification.

Please indicate your choice:

☐ **No**, the plan sponsor does not want to receive Protected Health Information and understands that it is exempt from the administrative requirements of the Rule.

☐ Yes, the plan sponsor wants to receive detailed Protected Health Information and it will comply with the administrative requirements of the Rule.

Employer Name: _____

List of Authorized Representatives

List any individual other than the plan administrator who will perform administrative functions for your group health plan and may have access to Protected Health Information (PHI) or summary health information. These individuals are authorized to discuss PHI that is the minimum necessary to administer the group health plan.

NAME AND/OR TITLE OF PERSON	COMPANY NAME

How does the authorized person use or disclose PHI in the performance of his/her job duties? _____

_____

(If more space is needed, please use another sheet of paper.)

NOTE: If there are any changes, additions or deletions to be made, the plan sponsor is required to notify Starmark within 30 days of the change.

Signature

I hereby represent that all the information herein, relative to this application and agreement, is true and complete and that I have read and understand the form. I understand that Trustmark will rely on these statements and this information in approving this application and in determining if the enrolling employees may become insured.

COMPANY OFFICER (Please print.)	PRODUCER SIGNATURE
TITLE (Please print.)	MANAGING GENERAL AGENT
COMPANY OFFICER SIGNATURE	DATE SIGNED

SERFF Tracking Number:	*TRST-128177448*	*State:*	*Arkansas*
Filing Company:	*Trustmark Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*12.00085*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.003A Small Group Only - PPO*
Product Name:	*S989C*		
Project Name/Number:	*Starmark 2011 Maintenance Filing/12.00085*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	05/01/2012

Comments:

Attachments:

Certification of Compliance Reg 49.pdf
Flesch Score Certification.pdf
AR Certification for 23-79-138.pdf
Certification of Compliance Reg 19.pdf

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	05/01/2012
Bypass Reason:	Application/enrollment forms associated with this certificate are attached under the form schedule tab for review and approval.		

Comments:

		Item Status:	Status Date:
Satisfied - Item:	PPACA Uniform Compliance Summary	Approved-Closed	05/01/2012

Comments:

Attachment:

PPACA Uniform Compliance Summary.pdf

		Item Status:	Status Date:
Satisfied - Item:	Cover/Filing Letter	Approved-Closed	05/01/2012

Comments:

Attachment:

AR_filing letter.pdf

Certification of Compliance

Trustmark Life Insurance Company hereby certifies that, to the best of its knowledge and belief, is compliant with the requirements of the Arkansas Insurance Rule and Regulation 49.

April 24, 2012
Date

Sandra Przybyszewski
Digitally signed by Sandra Przybyszewski
DN: cn=Sandra Przybyszewski, o=Trustmark Companies, ou=Vice President, email=SP7@trustmarkins.com, c=US
Date: 2012.04.24 17:24:39 -05'00'

Sandra Przybyszewski
Vice President, Compliance

Trustmark
Insurance Companies

Law Department

Phone 847.615.1500
Fax 847.615.3872

Trustmark Life Insurance Company hereby certifies that the form shown below meets the requirements under Arkansas Admin. Code 054.00.29-5 and A.C.A. § 23-80-206 and that the Flesch reading ease score of the form is as follows:

FORM	FLESCH SCORE
S989C	52

April 24, 2012
Date

Sandra Przybyszewski

Digitally signed by Sandra Przybyszewski
DN: cn=Sandra Przybyszewski, o=Trustmark Companies, ou=Vice President, email=SP7@trustmarkins.com, c=US
Date: 2012.04.24 17:30:24 -05'00'

Sandra Przybyszewski
Vice President, Compliance

Consumer Information Notice / Bulletin 11-88

Trustmark Insurance Company hereby certifies that, to the best of its knowledge and belief, it is compliant with the requirements of the Arkansas Insurance Code 23-79-138.

Sandra Przybyszewski

Digitally signed by Sandra Przybyszewski
DN: cn=Sandra Przybyszewski, o=Trustmark Companies, ou=Vice President, email=SP7@trustmarkins.com, c=US
Date: 2012.04.24 17:36:42 -05'00'

Sandra Przybyszewski
Vice President, Compliance

Date: April 24, 2012

ARKANSAS

Certification of Compliance

Trustmark Life Insurance Company hereby certifies that, to the best of its knowledge and belief, is compliant with the requirements of the Arkansas Insurance Rule and Regulation 19.

April 24, 2012
Date

Sandra Przybyszewski

Digitally signed by Sandra Przybyszewski
DN: cn=Sandra Przybyszewski, o=Trustmark Companies, ou=Vice President, email=SP7@trustmarkins.com, c=US
Date: 2012.04.24 17:15:12 -05'00'

Sandra Przybyszewski
Vice President, Compliance

PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

☐ **INDIVIDUAL HEALTH BENEFIT PLANS** ***(Complete SECTION A only)***

☑ **SMALL / LARGE GROUP HEALTH BENEFIT PLANS** ***(Complete SECTION B only)***

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as "major medical" in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. (*If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.*)

***For all filings, include the Type of Insurance (TOI) in the first column.**

☐ Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
Trustmark Life Insurance Company	276-62863	TRST - 128177448	S989C	☑ Yes ☐ No

PPACA Uniform Compliance Summary

Reset Form

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

Reset Form

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 of the PHSA/Section 1201 of the PPACA]*	☑ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: S989C/16a-04(R1)			
	Eliminate Annual Dollar Limits on Essential Benefits – Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☑ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: Unlimited for essential benefits - see schedule pages			
	Page Number: S989C/SCH-04			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☑ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no,** please explain.
	Explanation: See Schedule Pages			
	Page Number: S989C/SCH-04			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☑ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: See enrollment forms			
	Page Number: UW5 AR (R2) and UW2 AR (R8)			

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: See schedule pages			
	Page Number: S989C/SCH-04 and S989C/15-04 (R8)			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◊	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☑ **Yes**◊ ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: S989C/1-04(R3)			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: Our company's Claim-Appeal Notice AR was previously approved on 12-21-11 under SERFF#: TRST-127912401			
	Page Number: See above referenced filing			

◊ For plan years beginning before January 1, 2014, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: See schedule pages S989C/SCH-04			
	Page Number: S989C/13-04(R5),S989C/15-04(R8),S989C/27(R3),S989C/28(R4),S989C/29(R4) S989C/29-SN(R5)			
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: Not a contract requirement			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: Contract does not restrict access to OB/Gyne			
	Page Number:			

Trustmark

Insurance Companies

April 24, 2012

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201

RE: TRUSTMARK LIFE INSURANCE COMPANY
FEIN# 36-3421358; NAIC# 276-62863
GROUP ACCIDENT AND HEALTH
FORMS NUMBERS: UW2 AR (R8)
UW5 B AR (R2)

Insert Page Forms:

S989C	**S989C/16.2-04**	**S989C/39(R2)**
S989C/SCH-04	**S989C/16.3-04**	**S989C/42(R4)**
S989C/SCH(R1)	**S989C/18(R4)**	**S989C/44.1(R3)**
S989C/1-04(R3)	**S989C/23.1(R2)**	
S989C/1.1-04	**S989C/25-04(R2)**	
S989C/13-04(R5)	**S989C/28(R4)**	
S989C/13.1-04(R5)	**S989C/29(R4)**	
S989C/13.2-04(R2)	**S989C/29-SN(R5)**	
S989C/13.3-04	**S989C/29.1(R9)**	
S989C/14-04(R3)	**S989C/29.2(R9)**	
S989C/15-04(R8)	**S989C/29.2a(R6)**	
S989C/15.1	**S989C/29.3a(R2)**	
S989C/16(R3)	**S989C/29.3b(R2)**	
S989C/16a-04(R1)	**S989C/36(R4)**	
S989C/16.1-04(R5)	**S989C/38(R4)**	

Our File Number: 12.00085

Dear Sir or Madam:

Enclosed please find insert pages for use with certificate S989C, being filed for approval. The entire certificate was previously approved for use on July 24, 2006. An additional insert page(s) filing was approved on August 28, 2007 under SERFF#: TRST-125267324. These forms are new and will not replace any previously approved forms. The certificate is attached to an out-of-state policy, issued in the state of Illinois. These certificates will be marketed to small employer groups.

Also enclosed are employee applications to be used in conjunction with certificate S989C. Form UW2 AR (R6) was last approved on May 3, 2006. Form UW5 B AR (R2) is new and will not replace any previously approved forms.

With this filing we have incorporated benefits that are required due to changes in state law since the last form approval referenced above, as well as to accommodate changes required by health care reform.

The certificate forms are being submitted in an insert page format. Distinct page numbers have been assigned to portions of the documents in order to facilitate state exceptions and future revisions.

Bracketed text or numbers are variable and indicate material that may change based on options elected by the group, marketing philosophy, or changes in state law. Variable material will always meet the minimum requirements of law.
The forms are in final printed format as issued from a laser printer. We, however, use different computer publishing systems. Therefore, actual issued forms may have a different font style than the submitted forms. As a result, page breaks may occur at different lines and line wording may not match up exactly. The wording and its order, however, will remain identical. We do not anticipate re-filing for such font style variation.

Thank you for your time and effort with regard to this filing. If you have any questions, please contact me at 800-666-6977, extension 32338 or at SV4@trustmarkins.com

Sincerely,

Soula Vassilopoulos

Digitally signed by Soula Vassilopoulos
DN: cn=Soula Vassilopoulos, o=Trustmark Companies, ou=Compliance Analyst, email=sv4@trustmarkins.com, c=US
Date: 2012.04.24 18:27:37 -05'00'

Soula Vassilopoulos
Regulatory Advocacy Analyst
The Trustmark Companies